Tobacco Use: An American Crisis

Final Conference Report And Recommendations From America's Health Community

Washington, DC
January 9-12, 1993

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An American Crisis

Final Report of the Conference

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Conference Sponsors

American Medical Association

City of Hope National Medical Center

The Centers for Disease Control and Prevention

Coalition on Smoking OR Health

- American Cancer Society
- American Heart Association
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Editor, Thomas P. Houston, MD
American Medical Association

Tobacco Use: An American Crisis

Foreword

In only seven years, we will reach the date the US Department of Health and Human Services has set for a series of national health goals called "Healthy People 2000." The US Surgeon General has called for a "Smokefree Society by Year 2000." Looking ahead to that almost mystical date, members of the tobacco control community assembled in Washington, DC January 9-12, 1993 to discuss, plan, and issue a series of goals and objectives in twelve areas concerning tobacco and health.

Co-sponsored by the American Medical Association, the Centers for Disease Control and Prevention, the City of Hope National Medical Center, the Coalition on Smoking OR Health (the American Cancer Society, the American Heart Association, and the American Lung Association), the Memorial Sloan-Kettering Cancer Center, and the University of Texas M.D. Anderson Cancer Center, this conference represented a unique gathering of organizations and individuals concerned about tobacco use and its impact on health. Putting aside "turf" issues and differences in policy and priorities, over 200 participants were educated, stimulated, and challenged by plenary speakers and workshop activities.

This document includes several of the plenary addresses as well as reports from each of the work areas. Each workshop report contains background information relevant to the issue, and ends with a series of recommendations for the future for each area. The recommendations are also summarized at the end of this report. The conference sponsors hope that the proceedings will be a useful blueprint for the groups and individuals represented at the conference; local, state, and federal agencies and lawmakers; and others interested in preventive medicine and public health.

Since the early 1950's, medical research has brought our knowledge about tobacco and health from an observation made by a few physicians that related smoking with lung cancer to our current realization that tobacco use is the single most important preventable cause of illness and premature death in this country. More than 60,000 studies about tobacco use have made this the most thoroughly studied subject in medical science. A small sample of tobacco's impact on American society reminds us of the importance of tobacco control in public health.

- The annual total of premature deaths in America from tobacco use is about 434,000 persons. Smoking is the major cause of lung cancer, of deaths from emphysema and chronic bronchitis, and is a principal cause of heart disease and stroke. About one-third of smokers will die from a tobacco-related illness or condition—almost 25% of the total deaths in the US.

- Exposure to environmental tobacco smoke when nonsmokers inhale thousands of chemicals during "passive" smoking may kill as many as 53,000 Americans yearly. One analysis estimates that about 35,000 of these deaths are from heart disease; other studies, including new conclusions released by the US Environmental Protection Agency, project about 3000 lung cancer deaths from environmental tobacco smoke exposure each year. In addition, environmental smoke imposed upon children causes 150,000 to 300,000 cases of bronchitis and pneumonia each year, and worsens asthma in up to 1 million children annually.

- Smoking among adults has fallen to the lowest level in over 50 years, about 25%, but teen smoking has not changed significantly since 1980. Eighty-five to ninety percent of new smokers begin before age 20. About 3000 children begin smoking each day in the United States. The tobacco industry spends about $4 billion each year for advertising and promotion of its products, activities that recruit new smokers and attempt to convince current smokers not to quit.

- Increased health care costs, lost productivity and missed work, higher insurance costs, and higher maintenance costs in businesses in which employees may smoke are at least $68 billion annually.

Conclusions of the conference

Across different work groups, conference participants came to several points of concurrence that transcended their issue-specific areas:

Increase the Federal excise tax on cigarettes by two dollars per pack.

The present Federal tax on cigarettes, 24 cents per pack, puts the United States near the bottom of the list among the industrialized nations, which tax tobacco at a much higher rate. Conference

participants suggest $2 per pack as more in keeping with the health costs due to tobacco use. Even more important, it was estimated that a $2 tax increase will save 2 million lives over time. The tax would deter youth from starting to smoke, perhaps more effectively than any other single health promotion tactic. Adults would also have an increased incentive to quit smoking. Independent public opinion polls show broadbased support for a cigarette excise tax by over 70% of respondents. While not tying use of tax revenues to specific projects, participants agreed that the tax should be indexed to the consumer price index or another suitable marker that would keep the tax from being absorbed by inflation.

State governments should also raise the excise tax on tobacco products appriopriately. The California and Massachussetts experience shows that voters *will* pass a tax increase if it gets on the ballot.

Enable regulatory agencies to assume jurisdiction over tobacco products.

Cigarettes and other tobacco products are both the most dangerous and the least regulated consumer product in the country. It is the opinion of many in the health community that the Food and Drug Administration (FDA) currently has the authority to regulate tobacco products as drugs when direct or implied health claims are made. The FDA should be given specific statutory power by Congress to expand its authority to regulate the manufacture, sale, labeling, advertising, and promotion of tobacco products. The Federal Trade Commission should use its authority to regulate "unfair and deceptive" advertising, and the Department of Justice should enforce the ban on televised cigarette advertising currently being broken by tobacco industry sports promotions.

Protect the public, especially children, from environmental tobacco smoke (ETS) exposure.

As health professionals, we must educate our patients about the risks and dangers of ETS, and advocate for clean indoor air ordinances that protect the public from its harmful effects. This could cut costs related to acute illness among smoke-exposed children, and in the workplace, smoking bans would have the dual effect of health protection from ETS and help increase the number of adults that stop smoking.

Restrict the tobacco industry's advertising and promotional campaigns.

The tobacco industry currently spends about $4 *billion* each year on advertising and promotions. Banning sports sponsorships and other promotions and the tobacco industry's use of healthy, sexy, athletic models and cartoon figures in advertising should result in a decrease in tobacco use, especially among youth. At the local level, the health community should be vocal in opposing the tobacco industry's use of sports sponsorships and other promotional enticements, distribution of samples, and targeting of minority groups for high concentrations of advertising.

Foreword adapted from Houston, TP: Tobacco Control: Toward the Year 2000. *The Journal of Family Practice* 1993; 36:601-602. Reprinted with permission.

Acknowledgements

As chair of the conference planning committee, I would like to thank its members for their hard work, and the support from their institutions to the conference:

City of Hope National Medical Center
Karen Warren, Executive Vice President

The Centers for Disease Control and Prevention
Michael Eriksen, ScD, Director, Office on Smoking and Health

Coalition on Smoking OR Health
Alan Davis, American Cancer Society
Scott Ballin, American Heart Association
Fran DuMelle, American Lung Association

Memorial Sloan-Kettering Memorial Cancer Center
James Quirk, Senior Vice President

University of Texas M.D. Anderson Cancer Center
Harry Holmes, Associate Vice President for Government Relations

The committee sends special thanks to Jackie Craig, Margaret Garikes, Leslie Ludwick, and Michiko Sidney of the AMA; Joy Epstein of the Coalition, Karen Deasy and Gailya Walter of OSH, and also gratefully acknowledges financial support from the Roswell Park Cancer Institute and CIBA-GEIGY.

Ralph Reed, MD, of the AMA Washington staff, should also be remembered for his thoughtful assistance in planning the conference. Doctor Reed was forced to interrupt his participation with the committee midway through its work because of his fight against lymphatic cancer. His death reminds us of life's fragility, and of the importance of our task in preventing tobacco's contribution to its premature end.

Thomas P. Houston, MD
Director, Department of Preventive Medicine and Public Health
American Medical Association

This conference was supported in part by Grant Number R13/CCR507945-01 from the US Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

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Introduction

Joseph T. Painter, MD
President-elect of the American Medical Association

I would like to welcome you all to this meeting. I'm Joe Painter, from Houston, Texas, President-Elect of the American Medical Association (AMA) and have the privilege, on behalf of the organizations sponsoring this meeting, to welcome you all. Almost a year ago, during my tenure as chairman of the Board of Trustees of the AMA, I asked our staff to explore the possibility of convening a conference that would be a sequel to the 1989 meeting held in Houston, "Tobacco Use in America." Many of the same groups co-sponsored that meeting and have come together again to organize this weekend's conference.

I would like to recognize those groups who have worked together so well the last few months and have put together what I believe will an outstanding meeting. Representing the Centers for Disease Control, Dr. Michael Ericsen, who heads the Office of Smoking Health. I've known Michael for a number of years, when he was at M.D. Anderson, before going to his present post. He was a member of the conference planning committee. Representing the City of Hope National Medical Center, Karen Warren, its Executive Vice President and Chief Executive Officer. She also served on the conference planning committee. Representing the Coalition on Smoking OR Health are Dr. John Seffrin, EVP of the American Cancer Society, Dr. Alfred Munson, President-elect of the American Lung Association and finally, Mr. Dudley Hafner, EVP of the American Heart Association. Representing the Memorial Sloan Kettering Cancer Center, Jim Quirk, the Executive Vice President for Administration, who also served on the conference planning committee.

The other members of the planning conference committee should also receive thanks for their work. Dr. Tom Houston from the American Medical Association; the Coalition on Smoking OR Health has been represented by their steering committee: Alan Davis of the American Cancer Society, Scott Ballin of the American Heart Association, and Fran DuMelle of the American Lung Association. The MD Anderson Cancer Center was also represented by Dr. Harry Holmes. He's the executive assistant to Dr. LeMaistre, who will be our first speaker.

Like the 1989 meeting, this gathering of the tobacco control community is designed to consider a variety of elements in the tobacco control policy. The AMA is not only proud to be one of the sponsors and partners in this conference, but is committed to helping to forge a new dimension in trust, cooperation and joint effort as we fight to protect the health of the American public in the war against tobacco. Tobacco use is really an American crisis. This meeting can set the stage for the work that must be done to continue our progress since the previous meeting two years ago. Again, I welcome you to this task as we set about developing a program that will continue the fight against tobacco and the control of its use.

Tobacco Use: An American Crisis

Opening Remarks

Charles A. LeMaistre, M.D.
President
University of Texas
M.D. Anderson Cancer Center

Our conference title "Tobacco Use: An American Crisis" is most fitting. The awareness of crisis crystallized 29 years ago on a cold and bleak Saturday morning here in Washington. The setting was the State Department auditorium. The participants were carefully screened: The committee making the report had surprisingly passed muster with the voluntary health agencies—and the tobacco interests.

As it is today, the topic then was tobacco. And the message was the same as today—that cigarettes constitute a grave medical, economic and moral issue.

The occasion, however, was very different—a news conference, called by Dr. Luther Terry. He had summoned the media to release the findings of the first report of the Surgeon General's Advisory Committee on Smoking and Health.

The atmosphere that morning was tense; the security was tight—word had already leaked out—to the media and to the tobacco industry—that the findings were "explosive."

Saturday was chosen to minimize the impact of the report on the stock market, if you can believe that!

The media were escorted into the room, issued a copy of the report and, as incredible as it may seem today, the doors were locked behind them, just to make sure no copies disappeared prematurely.

Just how explosive was this evidence? Frankly, pretty tame, by today's standards. Listen to just a few of our findings, as they appeared in that first volume:

- "Cigarette smoking is causally related to lung cancer in men... The data for women, though less extensive, point in the same direction."
- Here's another: "The evidence on the tobacco-esophageal cancer relationship supports the belief that an association exists."
- And: "Women who smoke cigarettes during pregnancy tend to have babies of lower birth weight. It is not known whether this decrease in birth weight has any influence on the biological fitness of the newborn."
- And another: "Smoking is associated with accidental deaths from fires in the home."

And, in the spirit of assuaging those who might be offended, a chapter was devoted to the "beneficial" aspects of tobacco, and on the report cover were tobacco leaves.

And so it goes, as Linda Ellerbee would say. A document couched in *the most* conservative of scientific terms, yet a document that was to begin a revolution in American behavior, culture and health policy...

A revolution that began quite slowly and tentatively—one that would languish until the 1980's when for the first time anti-tobacco legislation passed Congress without compromise—and yet one that has been gathering increasing momentum in the years since.

But a revolution that is far from over—far too far from over, considering the weight of the preliminary scientific evidence that was already available in 1964, and the overwhelming evidence that has been amassed since.

On that preamble of reminiscences, I welcome you to this important conference on An American Crisis. An American Crisis that has been without a final solution for three decades and likely will continue for decades more at the rate progress is being made in bringing it under control.

What is the setting in which we meet to map strategy?

First, the problem is no longer a medical or scientific controversy. The problem is now societal—it is political—it is economic and it is moral.

Second, we must accept the embarrassment that it truly is an American Crisis—made in America—marketed and promoted in America and imposed largely by America upon the rest of the world through marketing—driven by disregard for human life and high regard for profiting, even if it involves the suffering of others.

Third, we consider this crisis at a time when America is preoccupied with another crisis—the unrelenting spiral in the costs of treating disease. Surprisingly few who talk about the cost crisis seem to understand the role of tobacco in the production of disease. Tobacco is by far the most significant cause of catastrophic illness, a primary driver of the rise in health care costs. Consider for a moment health care costs—less one-third of all cancer, less one-half of cardiovascular disease and less nearly all chronic bronchitis and emphysema.

Even so today we are better prepared to address this American Crisis than ever before.

Thank goodness, the conservative rhetoric of the first Surgeon General's Report has been replaced by plain-speaking that is both strident and understandable.

Thank goodness, we have moved beyond the individual, independent interests of agencies, associations and centers and now focus on the synergism that comes from working together.

Thank goodness, that we have rallied many, many more to the cause and that the collective impact of their effort is the reason why our country's mores changed so radically in the 1980's.

And thank goodness, we have learned a thing or two about communication and behavior change, about advocacy and marketing—so that we can meet the merchants of death on almost-equal footing.

And even now, three decades after the cause of the American Crisis was crystal clear, there are those who seek to soften the truth that is so patently obvious. Today tobacco remains the single most-preventable cause of illness, of catastrophic disease and of death. Today, tobacco is a highly profitable, legally manufactured and deadly product that neither our state nor federal governments have seriously attempted to regulate or control in the protection of the public's health. Today, in a blatant disregard for the rest of the world's health, our government has fostered participation of tobacco in favored trade status.

When in the light of human history, our American society is judged for its 20th century performance on social, moral and human values, we can indeed be proud that many achievements will resound to our credit.

Regrettably, the disgrace that is the American tobacco crisis will not be one that we can take pride in. It likely will be said that we have placed greed ahead of our regard for human life and concern for suffering.

We are but seven short years from the close of the books on the 20th century. There can be little doubt that we know the ultimate solution to this American Crisis. The only real unknown is whether you and I have the will to achieve the solution.

Now the time has come to do more, and who better to set the stage for our discussions than two great leaders in American health promotion. What a nice privilege it is to share the platform this morning with these two friends, whose contributions to the goals we share I admire so much —

My long-time M.D. Anderson colleague, Michael Eriksen, who has recently gone on to become the Director of the Office of Smoking and Health at the Centers for Disease Control, who will speak first.

He will be followed by Michael Pertschuk, whose taught us all so much about the power of persuasion, who co-directs the Advocacy Institute.

I am delighted to call Michael Eriksen to the podium now, and he will be followed by Michael Pertschuk.

"Healthy People 2000" and its Tobacco Control Objectives

Michael P. Eriksen, ScD
Director, Office on Smoking and Health
Centers for Disease Control and Prevention

Introduction

Today, my presentation is entitled "Healthy People 2000" and it is my goal to attempt to link the Year 2000 tobacco objectives to the recommendations that came out of the Houston Conference and to similar recommendations that might emanate from our current meeting.

Year 2000 framework

National objectives provide useful planning perspective for tobacco control in the 1990s. There are 16 major tobacco objectives which provide specific measurable targets for us to aim for. These objectives also cover most of the major contemporary tobacco control strategies (clean indoor air, advertising and youth access). There are specific gaps related to excise taxes and product regulation and hopefully during this meeting we can discuss ways of integrating conference recommendations into the Healthy People framework wherever possible.

Year 2000 progress

Analysis of our movement toward these objectives reveals a mix of good and bad news. Some of our key indicators:

First, the Good News....

Objective 3.4: Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older.

Last year we reported that U.S. adult smoking prevalence in 1990, the most current year of data available, was at its lowest point since the government first began national surveys—25.5 percent for the population overall.

Objective 3.11: Increase to at least 75 percent the proportion of worksites with a formal smoking policy that prohibits or severely restricts smoking at the workplace.

Eighty-five percent of workplaces have some form of smoking policies, up from 36 percent in 1986. And 59 percent of companies with 50 or more employees have policies that ban or severely restrict smoking—up from 27 percent in 1985.

Now, Some Bad News....

Objective 3.5: Reduce the initiation of cigarette smoking by children and youth so that no more than 15 percent have become regular cigarette smokers by age 20.

Overall smoking rates among young people have remained virtually unchanged over the past decade. In fact, smoking among male high school seniors actually has been inching up since 1987.

Smoking among black youths continues a dramatic decline that began more than a decade ago—daily smoking among black high school seniors now has fallen to 5 percent—one glimmer of hope we must endeavor to understand.

Objective 3.4b: Reduce cigarette smoking to a prevalence of no more than 15 percent among blue-collar workers aged 20 and older.

The rate of smoking among blue-collar workers did not decrease between 1987 and 1990 and is still nearly double the target level for the year 2000—37 percent vs. 20 percent.

Objective 3.12: Enact in 50 States comprehensive laws on clean indoor air that prohibit or strictly limit smoking in the workplace and enclosed public places.

Although all states but Montana have some form of laws restricting minors' access to tobacco, enforcement is virtually nonexistent in many states. We reported this year (from TAPS) that if 12- to 17-year-olds want to buy cigarettes, they have little or no trouble doing so.

Objective 3.15: Eliminate or severely restrict all forms of tobacco product advertising and promotion to which youth younger than age 18 are likely to be exposed.

Tobacco advertising and promotions that appeal to young people remain virtually unrestricted. There is a direct connection between the amount of advertising of specific cigarette brands and young people's preference for those brands—witness the success of Marlboro, Camel, and Newport in gaining the loyalty of new smokers.

The national response

I am pleased to report that we've made some real progress in accelerating tobacco control at the national and state levels.

For example, just 2 days ago here in Washington, EPA released its final risk assessment on ETS and respiratory disease. The designation of ETS as a Group A carcinogen (known to cause cancer in humans) by EPA along with NIOSH's classification of ETS as a "potential occupational carcinogen," provides us with powerful

new ammunition to work harder to protect the health of non-smokers. OSH is working closely with EPA to publicize the results of this report and to motivate the public to take action.

The American Stop Smoking Intervention Study for Cancer Prevention, or ASSIST, has entered its second year of planning and will begin full-scale implementation in 17 states this fall. At the same time, California enters a new year of activity in its statewide tobacco control effort with a reduced, but still remarkable, level of funding. Now the challenge is to provide necessary help to the other 32 states and DC so that they can take advantage of the training and technology developed for the ASSIST and California initiatives. We at OSH are hoping to do so, both by beginning to provide direct financial assistance to States' tobacco control efforts via a competitive cooperative agreement program, but also identifying, collecting and redistributing the best available tobacco control programs and materials among States and organizations.

In addition, the Preventive Services Block Grant legislation has been rewritten providing for greater opportunity for use of these funds for chronic disease prevention, including tobacco control.

The SCARCNET electronic tobacco control network, spearheaded by Mike Pertschuk and his staff at the Advocacy Institute, continues to be an invaluable source of news and intelligence for advocates across the nation. SCARCNET has made our jobs easier tracking such breaking issues as the Cipollone Supreme Court decision; efforts to divert funds from tobacco control in California; and the tobacco industry's unsuccessful attempt to derail the Massachusetts excise tax initiative.

The recently passed Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act now requires States to have minimum age laws for the purchase of tobacco products, and to *enforce* these laws—otherwise the states will lose a considerable portion of their federal block grant monies for substance abuse programs. We owe our thanks for this provision to the efforts of Oklahoma Congressman Mike Synar, who as it turns out was one of the congressional co-sponsors of the 1989 Houston meeting.

NCI, AMA, ACS, and a number of other professional organizations have continued a national initiative to train health care providers in smoking cessation. NCI hopes that 100,000 professionals will be fully trained by the end of this year.

The Coalition on Smoking or Health continues its persistent, focused advocacy to influence Federal tobacco control policy. Most recently, the day before the EPA "Group A" announcement, the Coalition held its own press conference to call for greater Federal and State clean indoor air legislation, regulation of tobacco products by the FDA, and a $2 increase in the Federal excise tax on cigarettes.

Our "activist" partners—DOC, ANR, STAT, GASP, and others—continue their aggressive, creative efforts at both the national and community levels to upset the status quo in tobacco control and bring about faster change.

I would give many more examples if time permitted. I'll let Mike Pertschuk expand on my list, which he will do from his keen and unique perspective. But it's my observation that there is more happening currently in tobacco control than at any time in our history.

Our charge now, and I use the word "our" in its most collective sense, is to orchestrate these efforts as strategically as possible. An unusual strength of the tobacco control movement is that it is extremely broad and decentralized—we never want to sap that strength with unnecessary bureaucracy or centralized decision making. But there's a clear need for greater communication and coordination, both to enhance what is already happening and to unlock new opportunities. That also is a theme that Mike will underscore emphatically.

Proposal for a unifying framework

Returning to my initial comments, I propose that this conference consider structuring its conclusions and recommendations in 1993 around the Healthy People 2000 objectives. Except for the issue of excise taxes, an important approach that I would support adding, the Healthy People objectives address all the critical components of a comprehensive tobacco control strategy.

These objectives already have broad-based support from both within and outside the public health community. They have been adopted and adapted by countless public and private organizations at the national, state, and local levels, and are actively being used to plan programs and establish budgets.

Though far from perfect, the Healthy People 2000 objectives benefit from being feasible, specific, and measurable—the three hallmarks of effective health promotion and disease prevention objectives.

Lessons from Houston

The Houston meeting 4 years ago made a valiant attempt to set a common tobacco control agenda for the Nation, but I think the impact of its recommendations has been tempered by two basic shortcomings: *over*ambition of purpose and *under*estimation of political reality.

First, the issue of overambition. The conference advanced 76 separate recommendations for controlling tobacco use, all of them thoughtful and insightful. But their sheer number and level of detail has, in my judgment, somewhat blurred the strategic vision of the conference organizers—to develop a common national agenda to reduce the death and disease caused by tobacco.

I don't mean for a moment to discount the outcome of that meeting. A number of its recommendations have been realized, and with considerable impact:

- Smoking was banned on all domestic flights, thanks largely to the efforts of Senator Frank Lautenberg and Representative Dick Durbin, who was the other Congressional co-sponsor of that conference.

- As a requirement for continuing accreditation, all hospitals soon will be smoke-free.

• And there have been other successes.

But now let me move to my second point, the issue of political realism. The six major recommendations of the conference dealt squarely with topics under the primary purview of the Federal Government: 1) regulation of all tobacco products by the FDA, 2) elimination of the Tobacco Price Support Program, 3) reversal of the government's international tobacco trade policies, 4) eliminating the influence of tobacco advertising, 5) increased excise taxes, and 6) action to protect nonsmokers.

These all are politically charged issues, owing to a single prevailing force: the economic enormity of the tobacco industry. We're getting smarter each day, but I still think we underestimate our foe and fail to learn all we can from its high-powered marketing and public relations machine.

But I'd like to end today by reflecting on what I believe is even more fundamental to the success of our mission than the issue of organizational process and goodwill. It's the issue of citizen involvement.

I've spoken in recent months to a number of state and community groups, from North Carolina to Arizona. I hear one consistent lament: despite the commitment, good ideas, and boundless energy of individuals working in tobacco control, they often find that the doors to substantive change are closed because of purchased influence by the tobacco industry at all levels.

The pervasive influence of tobacco interests on the entire political process has been demonstrated, in startling color, through recent reports leaked by industry lobbyists...through secret corporate memos obtained by our advocate-sleuths...through reports of tobacco company campaign contributions...through other industry documents subpoenaed for court cases...and through the bitter anecdotal experiences of our allies working in the field.

We now know, for example, that the industry willfully launched a massive misinformation campaign to undermine the credibility of the 1964 Surgeon General's report. The industry poured the same energy into its unsuccessful attempts to scuttle the EPA risk assessment and vilify the reputation of the agency itself. And ask our friends from California and Massachusetts about the behavior of the industry in those states.

What does this influence mean? It means, quite simply, that decisionmakers both in government and in organizations, at the local, State and Federal levels, are being paid for their silence on the tobacco issue. It means that these decisionmakers will choose not to bring a tobacco control issue out of committee ... choose to vote against a community smoke-free ordinance ... choose not to protect the health of children by continuing to allow teachers to smoke in school buildings ... choose not to include tobacco control in health promotion offerings to their memberships. It means that the best-planned tobacco control efforts may wither and die from failing to see the light of day.

Let me quote directly from Secretary Sullivan's remarks at Thursday's EPA press conference:

"Now it is time for our public officeholders of both parties to withstand the pressure of the tobacco industry to water down or defeat anti-smoking legislation—pressure fueled by millions of dollars in political contributions and additional funds to support so-called 'smokers rights' campaigns."

He continued: "Quite simply, if the concern expressed by our officeholders for the health and well-being of their constituents is to be considered genuine, then they cannot allow the tobacco industry to influence their decisions on issues of such vital importance as the health and survival of our citizens—particularly our children."

None of us at this meeting, even with our collective budgets, can fight tobacco influence with money. After all, how can we compete with an industry that reported *after-tax* profits of $7.2 billion in 1989—an industry that spends $4 billion just on advertising and promotion each year?

The only weapon we have as Americans is ourselves. Yes, we have the truth and the statistics on our side. And yes, we have public *opinion* on our side. But we really don't have the *public* on our side—not *actively* on our side.

To do that—to get people to embrace tobacco as a *personal* concern—we have to move far beyond the medical facts that smoking is harmful and addictive. We must instead educate people about the greed and influence of tobacco interests. We must stir people so that they view tobacco with social and moral outrage. We must publicly shame the tobacco industry for their actions.

We must raise the issue of tobacco control on people's personal agendas so that they will talk to their neighbors about it—testify publicly about it—and consider it in their actions, including their voting decisions about political candidates.

I believe decisionmakers will turn down tobacco money only when they perceive such contributions to be a political liability. For that to happen, everyday Americans must voice their concerns—loudly and consistently—about how the tobacco industry's self-interests are perverting our very system of democracy, and how they will translate that concern at the ballot box. Only then will tobacco money become worthless, and the tobacco industry lose its influence. We must strive to create a *national indignation*.

But how can we mobilize the citizenry? This same concern was expressed at this same meeting four years ago:

"Collectively, the participating organizations can mobilize millions of citizens at the grassroots level to create a strong coherent body able to more effectively influence and educate policy-makers throughout government."

But I say that it will take more, much more, than getting our health constituencies involved. We must get involved the very people who are not part of the "movement." We must get *all* of America involved!

I am heartened at the presence at today's meeting of the "Interreligious Coalition on Smoking or Health" who can begin to bring *our* message to the homes of *all* Americans through the churches—the United Methodist Church, the Church of Christ and others. We must work not only through the churches, but through all other possible avenues to get the word out—the word, not that smoking is bad for you, but the truth about the industry, its tactics and the aftermath.

Unfortunately, the tobacco industry has not only influenced government officials, but has also financially contributed to other natural allies and avenues to the American public—NOW, NAACP, unions, progressive groups ... the list goes on.

Clearly, we're not going to solve this problem today, but in my opinion, there was never a better day to start. We have recently enjoyed many successes, public opinion, as evidenced by Doonesbury, Ellen Goodman, Anna Quindlen and George Will has never been stronger. There is a certain electricity in the air anticipating the potential of a new administration, but also fearing that the industry will be one step ahead. Our challenge is to make tobacco control not our issue, but America's issue.

At this time, in this city, I feel it's appropriate to repeat one of the most famous quotes of our generation:

"All this will not be finished in the first 100 days, nor will it be finished in the first 1000 days, nor in the life of this administration, not even perhaps in our lifetime on this planet.

But let us begin."

Thank you.

Opportunity Knocks; Will We Open the Door?

Keynote Address

Michael Pertschuk
Co-Director,
Advocacy Institute

As we look back over the four years since many of us met in Houston, how have we done?

Are we winning?

Are we losing?

Have we set our horizons high enough to challenge us to the utmost, but realistic enough to be achievable?

And have we marshalled our will and our resources to achieve the achievable?

In some ways, it's hard to tell. If we look at Canada, or Australia, or Thailand and Taiwan—even that last bastion of aggressive Gauloise-blowing, France—we must look with admiration and not a little envy.

But if we look at Germany or Japan, and most of the Third World—and if we acknowledge that we face the most concentrated and politically potent tobacco industry opposition—we're not doing so badly.

As we take stock, it's hard not to be assailed by competing images, some of which herald great progress; others, just as compelling, auger stagnation.

• The Massachusetts Division of the American Cancer Society and the coalition it led with great skill and persistence, with heart and soul, withstands an $8,000,000 onslaught by the tobacco industry to emerge triumphant in its vanguard cigarette excise tax initiative.

• In a small meeting room in Springfield, at the annual STAT Conference, a group of tobacco control advocates bitterly vent their frustrations at their felt exclusion from the 17 state ASSIST coalitions, reflecting deep resentments that the activists who are the most dedicated tobacco control freedom fighters remain unappreciated, uninvited to the table, unsupported, while, as they see it, bureaucrats wallow in misdirected tobacco control dollars.

• Yet in Raleigh, North Carolina, where tobacco control requires a quality of fortitude and courage which few of us are required to match, an ASSIST launched conference, packed to standing, deals openly and courageously with the challenges of fighting tobacco in the very states for which tobacco is the perceived economic life blood.

• One thousand tobacco control workers gather in Los Angeles to celebrate three boisterous years of Prop 99—an ethnic rainbow of newly minted, enthusiastic, resourceful tobacco control advocates who have radically altered the community environment for tobacco use in California—under the risk-talkng, politically unintimidated guidance of the California state health department staff.

Yet, look around this room. Nationally, we are no rainbow coalition—and the very communities which are the prime marketing and propaganda and organizing targets of the tobacco industry are largely missing from the councils and inner coalition core of most tobacco control efforts.

We have come together here today with a shared vision for the future:

First, to achieve an authoritative, comprehensive, articulated National Tobacco Control Policy Agenda, setting concrete national, state, and local objectives and strategies for tobacco control.

Simultaneously, to forge an organized core of universally accepted leaders and leadership groups, as in Canada, capable of developing and directing coordinated national campaigns to achieve priority policy objectives.

But before we can do that, we need to deal openly and honestly with both our strengths and our current limitations.

Let me begin by offering for your consideration over the next few days what strategic planners call a SWOT analysis of our movement as it now stands: our internal *strengths*, our internal *weaknesses*, the new external *opportunities* that beckon to us, and the *threats* that shadow our best efforts.

What are our strengths?

I come up with no less than 11—they are formidable —and we need to take just pride in them:

1. Among mainstream tobacco control advocates, there does exist broad consensus on the four horsemen of tobacco control policy: 1) excise tax increases; 2) extending smoke-free public places; 3) curbing advertising and promotion; and 4) restrictions on youth access.

2. The movement has brought forth a talented and diverse leadership pool: federal and state legislators, such as the 50-member

—and growing—Congressional (i.e., House of Representatives) Task Force on Tobacco and Health; public health advocates both in and outside of government; deeply committed, energetic, and effective grass roots activists, including activists within the health voluntaries, researcher/activists; lobbyists and advocacy specialists.

And we are fortunate in being able to draw upon the successes and the battle-tested expertise of our skilled Canadian colleagues.

Among these leaders, there exists a potential core group capable of providing coherent, respected, collective direction, a goodly number of whom are convened here today.

3. In Washington, the tri-ageny Coalition has developed the framework for a national legislative program. And it has just launched a timely and ambitious federal excise tax initiative around which all of us can now mobilize.

   It coordinates its state affiliates, has built good working relations with key legislators and staff, and is now developing a capacity for influencing the new Administration's policies. It draws support from as many as 150 national organizations.

   Individual members of the Coalition have played lead roles in tobacco control campaigns, most recently the campaign to achieve smoke-free international skies, and the effort to force the FDA to take responsibility for regulating tobacco products.

   And, in convening this meeting, the members of the Coalition and the AMA have signaled their recognition of the need and their commitment to strengthen the cohesion and capacity of our national tobacco control movement.

4. ACS, with new leadership at the top, strong mid-level leadership on tobacco control, the sweet taste of success in the Massachusetts excise tax initiative, and a long-term commitment to the ASSIST coalitions, is poised to commit substantial new funding and new national direction and energy to tobacco control.

5. The AMA House of Delegates has been in the vanguard calling for strong action against tobacco advertising and promotion. Key AMA leaders and staff like Ron Davis and Tom Houston and the editors of JAMA have provided strong leadership, and the AMA has begun to mobilize actively, as with its sponsorship of the Chicago protest march against the "Joe Camel" advertising campaign.

6. From ANR to DOC to GASP to STAT to Smoke-Free Pennsylvania, activists, the shock troops of tobacco control, with dauntless determination, almost no money and institutional support, but awesome energy, have been the sparkplugs of change in city after city, state after state, throughout America. ASH, and others have forged good and mostly successful state legislative battles to stop or disarm mischievous and diversionary Smokers' Rights laws.

7. The 17 state ASSIST site coalitions are gaining rapidly in capacity and cohesion. Through NCI, ASSIST is providing a planning, technical support and staffing structure for sustained policy advocacy initiatives for the five years beginning in September, 1993. And, despite the perception of some activists, NCI and ACS are committed to bringing the grass roots activists into the fold.

8. The Office on Smoking and Health (OSH), with strong CDC support, has signaled its readiness to commit its resources, its convening role, and its leadership voice to achieving a national infrastructure and strategic plan/planning process. It has new resources, is likely to gain more, and has already been building a support system for state health department tobacco control officers. OSH is perceived as both committed and neutral among the players, and has shown its readiness to reach out to previously outlying constituencies.

9. California's massive resources, learning, and technical support infrastructure can be drawn upon to support national efforts.

10. The emergence of such organizations as the National Association of African-Americans for Positive Imagery (NAAAPI) and the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO) hold great promise for new, concentrated efforts to draw critical ethnic groups into full and equal partnership in tobacco control.

11. (With all due modesty), the Advocacy Institute provides a generally trusted, respected, independent core of policy professionals committed to strategic planning and coordination of tobacco control policy advocacy, and SCARCNet is close to achieving optimum reach as a universal communications and technical support pillar for media and policy advocacy initiatives.

These are our strengths—that's the easy part. Now the internal weaknesses. Forgive me if I tread on toes. But this week marks my 60th birthday, and I feel both obligated and entitled to engage in unaccustomed truth telling:

And, in truth, while we have many able and talented and committed leaders, that leadership is fragmented. The limited financial resources committed by both government and non-government funders are, too often, mis-directed. We still lack the structures and capacity for overall priority setting, strategic planning, tactical coordination, and effective communications.

Specifically:

1. Other than the modest "Healthy People 2000" objectives, there exists no comprehensive, authoritative national tobacco control policy.

2. Among the federal agencies, NCI, which earlier shamed CDC by the boldness of its ASSIST initiative has lately weasled and waffled on its commitment to full funding of ASSIST. EPA drops ETS research. The FTC has been guilty of false and misleading promises by failing to match with action its rhetorical commitment to challenging such blights as the Joe the Camel campaign. FDA reacts to calls that it assume jurisdiction over tobacco products as if it had been tossed a red hot coal. HHS gingerly omits excise taxes from the Healthy People 2000

objectives. And OSH has yet to put its new money where its mouth is. We are still awaiting the White House executive order decreeing a government-wide non-smoking policy. The Office of Trade Representative has not quite finished pushing Virginia Slims advertising campaigns down the throats of countries who would spare their not yet smoking women that blight.

Perhaps the good riddance of the Quayle-Sununnu White House will remove the hidden encumbrances to action by these agencies. Perhaps.

3. In DC, the Coalition on Smoking OR Health is essentially limited to the Cancer, Lung, and Heart voluntaries. While enlisting support from other organizations, the Coalition has had limited success in forging close alliances with the rest of the tobacco control movement. The leadership of the three major voluntaries have provided the coalition with the barest of staff resources. It operates with only a small staff and no full time tobacco control lobbyists, and, while the Coalition has access to other staff and volunteers, tobacco control advocacy is only one of many issues engaging the voluntaries and their Washington offices.

   At the same time, it has been the three voluntaries alone who have committed staff time and resources to federal tobacco control lobbying—which is more than can be said of other national groups nominally committed to tobacco control, some of whom are quick to carp at the Coalition.

4. The AMA has never applied its formidable lobbying resources to tobacco control with anything resembling its legendary mobilization on health care issues.

5. While ASH's voice is loud, it shuns alliances and its legendary fund raising capacity dwarfs its tangible contribution to tobacco control mobilization.

6. The African-American, Latino-American, women's, and labor communities are wooed by the tobacco industry, and neglected by the tobacco control entities (except the California Health Department). The ASSIST coalitions are nominally committed to such outreach, but little true diversity has yet been achieved in the working cores of these coalitions.. NAAAPL, for example, lacks any financial or staff underpinning.

7. The Carter Center has the potential to help with both strategic planning and broadened outreach, but it lacks both human and financial resources.

8. Too many activists are alienated, envious, obsessed with column inches envy, intolerant of moderate or divergent views. They are offensively self-righteous. They are chronically underfunded in proportion to their undoubted contribution to tangible policy achievements and are chronically resentful.

9. As a resource center, responsive to tobacco control advocacy groups (and its funders), rather than a "front line" advocacy group, the Advocacy Institute is only able to make indirect contributions to the movement's strategic cohesion. A number of activists have not too gently suggested that the funds spent to support the communications and technical support activities of the Institute would be far more effectively invested if they were divided among the activists who actually work the front lines of tobacco control. And they may be right. (Though we hope not).

(If I've thoughtlessly overlooked any of you, please let me know. I'm confident I can find something at least equally offensive to say about everyone here. After all, none of us are perfect. Or close.)

These weaknesses are the more painful as we move into a new era of opportunity—opportunity which we may simply not be ready to seize:

Among these external opportunities are the following:

1. The new Administration offers hope and promise for the emergence of a broader, bolder national tobacco control policy. Though hardly single-minded crusaders, the President-elect and Hillary Clinton have taken both personal and policy stands against smoking—a sharp contrast, for example, with all earlier presidential candidates. Donna Shalala was a strong advocate of non-smoking policies both within the University of Wisconsin and the city of Madison; Bob Reich worked on tobacco control initiatives at the FTC. I would be surprised if the Clinton FTC transition team has not called for aggressive action by the FTC challenging youth-oriented cigarette advertising such as the "Joe Camel" campaigns. Though it should be noted that, while issues ranging from AIDS to health care reform are receiving considerable attention, no clear Administration leader on tobacco control has yet emerged.

2. The new Congress offers hope. Changes in the make-up of the House Energy and Commerce Committee, the House Appropriations Committee, and the Senate Labor and Human Resources Committee, among others, may advance tobacco control initiatives —especially if these are supported rather than resisted by the Administration. The Congressional tobacco task force is growing. The Women's Caucus appears ready to embrace tobacco control on its health promotion agenda. And tobacco control leaders in the House and Senate are poised to pursue a broad and ambitious tobacco control agenda. And Jesse Helms quit smoking.

3. As the Administration's health care reform proposals take shape, two opportunities emerge; 1) sentiment approaching consensus that cigarette and alcohol excise taxes are a preferred source of revenues to fund an improved system, and 2) growing interest in developing a prevention component of the reform package, including tobacco and alcohol control policies.

4. Momentum grows at federal, state and local levels for cigarette excise taxes, clean indoor air policies, and effective restraints on youth access. There is less momentum, but broad public support, for restraints on advertising and promotion.

5. Analysis of media content and tone reveals constant progress (for which we do claim some modest credit) in delegitimizing the tobacco enterprise, thereby undermining its political power to resist and deflect appropriate tobacco control policies. For

example, the furor and focus on Vernon Jordan's RJR connections highlighted the negative ethical implications of all such connections. Michael Eriksen is dead right. Pursuing the public shaming of all those who are prepared to profit, even remotely, from the death and debilitation caused by smoking is a primary building block for our efforts.

We know the main source of our external threats: the transnational tobacco companies. We may nod, but the tobacco industry never sleeps. While their moral resources erode, their financial resources are inexhaustible. And they continue to be able to buy a vast army of lobbyists, propagandists, and lawyers—among them, alas, otherwise worthy community leaders and vanguard community organizations.

Thanks again to the uncanny intelligence gathering efforts of DOC, we now have newly liberated Philip Morris internal lobbying memos to remind us that the industry's campaign contributions and the tobacco ties of key transition figures and nominees will be a constant threat to uninhibited tobacco control policies.

But the industry is not the only threat to tobacco control progress.

Ignorance—sometimes willful—among both the public and policy makers as to the enormity of tobacco's toll persists. Thus, competing claims on the public agenda—such as AIDS, illicit substance abuse, and pollution—are still perceived as more serious and more pressing.

A third threat is complacency—complacency in the face of real gains in tobacco control.

What does this snapshot—these strengths, weaknesses, opportunities, threats tell us about our tasks over the next three days?

Let me suggest that, as we address the range of specific and critical issues which we have assigned ourselves, that we pay heed in each meeting—and in the invaluable informal networking which links us—to our meta-needs;

• With a new Administration which gives promise of more openness to tobacco control initiatives, we need to revisit both "inside" and "outside" strategies: what can we realistically expect from an enlightened Administration, and how can we help make sure that what might happen does happen? When and how should we expect to join forces with and coalesce to support OSH, NCI, the state health departments?

• When and how best can we maintain outside pressure on government to make sure it remains upright?

• Specifically, how can we combine to develop a strategic plan to achieve a National Policy on Tobacco Control issued and embraced by the President?

• And how can we best maintain constant vigilance over the insinuating influence of tobacco industry money and agents on the nascent policies of the new Administration?

• How can we broaden and strengthen existing coalitions, both at federal and state levels, including:

finding the will and the ways to open up our coalitions to true partnership and cooperation with all significant tobacco control entities, allowing ample room for independent, but coordinated initiatives led by those with the energy and skill to move beyond coalition consensus priorities.

building bridges of financial support and understanding to the grass roots activists.

meeting the needs and concerns of ethnic communities and leaders in shaping the tobacco control agenda and leadership structures.

• How can we help provide financial and technical support for emerging ethnic tobacco control leadership networks?

• How can we strengthen the technical support infrastructure, especially strategic communications and coordination including timely intelligence on tobacco industry strategy and tactics, counseling on counter-stategies, policy guidance based upon sound research and analysis and ready access to key data bases?

• And finally, how do we find within ourselves the internal, spiritual resources to reach out to each other as friends and allies in a great cause, transcending the self-righteousness and meanness of spirit, the pettiness and vanity, the personal and institutional self-interest that too often corrode our efforts?

Coming together is our start. Leaving united is our challenge.

Tobacco Control Battles: State Legislatures

Excerpts from the Remarks of
New York State Assemblyman Alexander (Pete) Grannis

The tobacco control movement has no lack of information about the issues and about what needs to be done to help reduce tobacco use in this country. Advocates need to focus on how to accomplish their goals. Because this conference is being held in Washington, D.C., the focus appears to be on the federal government, but I would urge you to focus on the other end of the political system, local government.

New York (city and state) has achieved many recent policy victories. Cigarette advertising will be banned on mass transit. Smoking is banned in New York City schools. The state has banned vending machines that are available to kids. Free distribution of cigarettes is banned. Proposals have been made to strengthen the state clean indoor air act. Enforcement procedures have been changed from criminal to civil in the youth access legislation. Parents now have the right to initiate action against retailers who sell cigarettes to their children, along with licensing requirements for cigarette vendors, requirements for IDs for cigarette purchasers. An increase in the state excise tax is in the works.

Tobacco control legislation is no easier to pass in New York than any other state, but we have had success by starting first with local government. This strategy divides and dilutes the cigarette companies' ability to use their resources. It is harder for the companies to work at the local level than at the state level. A number of counties had clean indoor air legislation before the state. Local governments have been enacting their own restrictions on smoking in public places.

When state legislators saw those actions going ahead with popular support and no damage to the local politicians who promoted them, they became interested. We worked on the state clean indoor air law for 13 years. As local governments moved ahead, we were able to pass our bill almost unanimously in both houses of the legislature. And then came other successes, especially the adolescent tobacco youth prevention act.

Among the groups that helped us to get this legislation passed were local public and private agencies, local components of the American Cancer Society, American Heart Association, and American Lung Association, and citizen advocates. They were very effective. People in the field were writing letters, visiting legislators, talking to the media, and questioning legislators whose votes allied them with cigarette companies.

In particular, we organized 130 groups throughout the state that brought school children to Albany. Teachers had class projects that used the adolescent tobacco youth prevention bill as a civics lesson. Legislators who would not normally have been supporters of tobacco control legislation were a little intimidated when faced with a teacher and 30 third grade students. The students asked their legislators to pledge to support the bill. When one legislator who had pledged his support to the children voted against the bill, a press release was sent to his district pointing out that he went against his pledge. That only had to happen once. The next time around, that legislator supported the bill right away.

In addition to the effective tactics of the coalition, we were helped by the pressures of an election year and the uncertainties generated among legislators by reapportionment. We were in a good position to persuade legislators to do what was right in 1992.

Looking ahead in New York, we expect the governor to propose a cigarette tax increase. His focus will be on the revenue that the tax will provide, but it will also advance the health agenda. The emphasis on revenue will help force an issue that otherwise might not find support in the state legislature.

Again, I urge you in to consider recommendations that are aimed not just at Congress. You should have recommendations that are targeted with as much directness as possible on local governments. That is where we will win the fight. We can make a real difference by getting the tail big enough so that the dog cannot ignore that it is being wagged.

In closing, I would like to add that you should try using a little humor in fighting the tobacco companies. One year, I decided to have an April Fool's Day press release describing a state wide effort by school children to have cigarettes declared the official New York state poison. The release was dated April 1 and said it was not for immediate release. National Public Radio, AP, and some local newspapers used the story anyway. When the press discovered the story was a joke, they were not pleased. So after all the fuss, I did turn the proposal into a bill. This issue got the public's attention when we used a frivolous approach to a serious issue. Humor can be a useful tool in trying to get a message across. While the issues are serious, humor can provide a way to focus attention on the tobacco industry.

Tobacco's Targets: Minorities and Women

Remarks of
California State Senator Diane E. Watson

Good Morning Ladies and Gentlemen.

I appreciate the opportunity to speak to you today, particularly, because I feel so passionately on the subject before us. I have been asked to speak to the special concerns of women and minorities as targets of tobacco marketing and the effects of this exploitation.

The market targeting of minorities and women is symptomatic of the corruptive influence of the tobacco industry. This influence penetrates and demeans our nation's journalism, science, politics and economics. The corruption is pervasive, and symbolizes that which is worst in our social/economic system. The pernicious influence of the tobacco industry, based on obscene and perfectly legal profits, tells us something important about the moral character of this country. In this country we condone an industry that addicts children and murders the elderly. We knowingly accept, in the name of commerce, a business that afflicts the most vulnerable and defenseless members of our society. The continued sale of this addictive, destructive drug is made possible only by an extended and complex perversion of our public institutions.

I would like to explore with you briefly, *how* we continue to accept a product that appeals exclusively to children, that ravages minorities and women, and yet enjoys the sanction of law and protection of government. This condition is nowhere better demonstrated than in its impact on minorities and women.

There is no doubt, despite claims to the contrary by the industry, that tobacco companies target women and minorities. This is done through massive media buys in targeted market areas and through the creation of special brands like "Dakota," "Slims," or "Uptown." In California's central cities and African-American communities, it is not uncommon to find four of every five billboards advertising alcohol or cigarettes. Tobacco advertising is the principal support of a great many minority publications. Tobacco is the primary sponsor of women's sports and magazines. Hundreds of millions of dollars are spent on marketing for minorities and women, and it is obvious to anyone who cares to look. I think we can all stipulate that targeted marketing is central to maintaining cigarette sales.

Why do tobacco companies target minorities and women? Simply because these populations are the most vulnerable. They will, for a variety of complex reasons, buy a product that most adults reject out of hand.

It is important to keep in mind that while this product is sold to adults, it is initiated exclusively among *children*. Marketing or advertising aimed at minorities and women is in fact aimed at minority children and adolescent women. Smoking is a symbolic act for the young. It is most often associated with blue-collar, urban, disaffected lifestyles. It is a symbol of defiance, independence, rebellion, sophistication and a rejection of traditional values. It is all these things because a $4 billion annual media effort creates this image.

Can you imagine anyone who would be more responsive to such a message than disaffected, adolescent, urban minorities longing for an independent identity—or young women caught up in the emotional turbulence of puberty and initiation into the adult world?

Who else lacks the education, discipline and experience necessary too ignore the calculated appeal of smoking? In truth only one other population is as vulnerable to smoking's appeal as minority and female children. This is third world minority populations. Economically vulnerable, medically unsophisticated, and consciously longing for symbols of western sophistication, these foreign populations provide the consumer stock for future commerce in tobacco.

The tobacco industry is fully conscious of who it has to sell to, and obviously, targets both domestic minority and female children as well as unsophisticated populations in South America and Asia. There is no great secret here. This is common knowledge. It is familiar to all of us and most of the world. The *average* age of smoking initiation in the United States today is 12 and a half years. This state of affairs is accepted only because of smoking's long history and the pervasive corruption of public institutions.

The results of this targeted marketing are predictable. Smoking rates are higher among African-Americans than whites, quitting rates are lower, and age adjusted smoking death rates are 12 percent higher for African-Americans. The average lung cancer death rate for African-Americans during the 1980's was more than double that of whites. Among those of my heritage, there is a well established and disproportionate predisposition to heart disease, hypertension, and cancers of the lungs, cervix, throat, bladder and kidney. These are the primary afflictions resulting from tobacco use, and African-Americans suffer disproportionately from every single one of these diseases.

Among the most vulnerable and susceptible of our citizens, tobacco is the single largest preventable cause of death in this nation. In this simple fact is demonstrated the cruelest, most mercenary exploitation of children in the world today.

This exploitation is sustained by a far more extended corruption than the legal sale of an addictive drug to innocent children. This corruption, fueled by obscene profits, seeps into the very core of our society. This corruption afflicts our government, institutions, our community leadership, our commerce, our science and our journalism.

Tobacco profits finance the co-option of leadership within minority communities. Millions of dollars annually are spent to support legitimate and committed minority service organizations. This money buys tobacco the silent approval of many in the minority community. My office has seen tobacco memos, for example, which compared minority recipients of tobacco dollars, and the relative value these organizations provided in the fight *against* California's tobacco tax.

The influence of tobacco contributions to public officials is well-known and widely documented. In California, where we have seriously threatened tobacco interests, we enjoy the dubious distinction of having the single largest individual recipient of tobacco political contributions. One hundred and nine of 120 California legislators receive tobacco contributions. For 15 years, this pernicious influence prevented any significant restriction on tobacco use. For 20 years, this influence prevented any significant federal interference in tobacco consumption. This influence perverts a critical purpose of democratic government. Government is intended to protect those unable to defend themselves—yet our government has twisted this responsibility to protect the weak into tax breaks and subsidies and legal shelter for this lethal industry.

The pattern of perverting the purpose of public institutions is repeated in journalism, commerce and science.

Several long-term studies have found a direct, negative, correlation between a publication's tobacco advertising revenues and coverage of tobacco stories. During California's aggressive anti-tobacco media advertising campaign, numerous outdoor and television advertisers refused to sell us space or time. They feared retaliation of tobacco company subsidiary advertisers. Tobacco advertising revenue is able, on occasion, to control journalistic editorial policy. The industry makes a special effort to silence minority publications.

In business, the profits of selling death to children overcomes any hesitation an investor may feel in helping to kill thousands. Selling cancer to third world populations is "just business." The single most widely held stock among institutional investors in this country is Phillip Morris. Last year, *Time* magazine named R.J. Reynolds the best managed company in the nation. Business claims not to make moral judgments—only business decisions. But the investors, retailers, growers, shippers and advertisers who profit from tobacco give moral sanction to the avoidable death of thousands.

The corruptive influence of tobacco and tobacco profits on science has gone on for a long time. The tobacco industry subsidizes dozens of "scientists" to grind out sympathetic studies, confusing interpretations, and misleading conclusions. While such studies enjoy no credibility, the industry has been capable of disputing or preventing legitimate research on the effects of tobacco usage. A single state, California, now produces more tobacco related research than the National Institute of Health and all major foundations combined. This means that until California's public acted, diseases which kill 400,000 people every year received hardly any attention.

These circumstances represent a profound moral failure. The influence of the tobacco industry and its corruption of our public and community institutions is tragic. We condone the addiction of children and death of the elderly.

Government and community leaders surrender their integrity out of avarice and our national character turns a tidy profit selling legal dope to the poorest and most defenseless people on earth.

It is easy to condemn an industry which cripples our population. It is convenient to don a holier-than-thou attitude and assume a superior attitude. But the blame for this circumstance falls on all of us. It falls on the minority community for not demanding change. It falls on my colleagues in public office who turn a deaf ear to demands for change. It falls on a business community which makes tobacco available and on our media and scientific communities who allow themselves to be used for the monetary gain of others.

I realize this is a sweeping condemnation. But some shock is necessary. Tobacco is such a familiar, accepted affliction that we tend to forget its fearsome toll. We cannot undo the insidious and sophisticated fraud of generations without bold strokes.

Despite this depressing assessment, I believe tobacco use will continue to diminish in this country and worldwide. The EPA's recent confirmation of the harmful effects of second-hand smoke should unleash a hail of liability claims in workplaces and public places across this country. Finally, tobacco users may have to take responsibility for at least the injury they do others.

In California, we have tripled the quit rate of the general public through counter advertising. In this Nation's cities, tobacco use among minority children has been cut in half, due principally to new social attitudes.

We need to recognize the culpability of our social and economic institutions. We need to hinder the practice of smoking at every turn, and we must never stop.

Challenges in Tobacco Control

Keynote Speech

Antonia C. Novello, MD, MPH
Surgeon General
US Public Health Service

Good afternoon ladies and gentlemen, colleagues, and distinguished guests.

It is an honor to join you—our country's top leaders in the tobacco control movement—at this important and compelling conference.

So much has happened since we last came together at our 1989 meeting. Because of our hard work, we are enjoying many successes—thanks in large part, to your leadership, your vision of a healthier society, and your success in fostering an atmosphere of collaboration and cooperation.

This conference couldn't have come at a better, more opportune time. What a whirlwind week we have just had—a week, I assure you, that the tobacco industry will not easily forget!

All of us have gained a tremendous, renewed sense of confidence and vigor by EPA's long-awaited endorsement: an endorsement that showed that exposure to secondhand tobacco smoke does, indeed, causes lung cancer in non-smoking adults and greatly increase of risk of respiratory illnesses in children.

It's about time the public knew the facts and risks, and understood the severe consequences.

But most importantly, it was also about time that our government shared its concern with its citizens.

The CDC's public information campaign launched Thursday to inform Americans of the dangers of secondhand tobacco smoke is also a major step in getting the public to think, precisely, along these lines. Their campaign action guide, "It's time to Stop Being a Passive Victim," puts prevention in the hands of the individual—where it truly belongs.

Your presence here, under one roof, during this exciting time of opportunities just waiting to be tapped—is very significant, indeed.

It sends a powerful message to the industry, loud and clear, that we have had enough of the smoke and mirrors, enough of the mombo jumbo, enough of the relentless distortion of facts into fiction. We are here, we are prepared, we mean business, and we are not going to take it anymore.

As Surgeon General, the issues that lie at the heart of tobacco control are of great concern to me—those that pertain to tobacco use by our youth, the increase in use by women—particularly young women—and the targeting of women, children, and minority groups by the industry.

I have always devoted a large portion of my agenda to opening the eyes of those who may not yet see the real hazards and risks of tobacco use. And I assure you, as long as I am Surgeon General, *I will not let up*; not when so much more remains to be done.

Because I feel so strongly about this subject, it is especially rewarding to see the solidarity shown by the presence of so many cosponsors at this conference.

What a tremendous line of hardhitters we have here:

- The American Medical Association;
- The Centers for Disease Control (OSH);
- The City of Hope National Medical Center;
- The Coalition on Smoking OR Health—made up of the American Cancer Society, American Heart Association, and American Lung Association;
- The Memorial Sloan-Kettering Cancer Center; and
- The University of Texas M.D. Anderson Cancer Center.

I know that in these few critical days, we will all have a chance to renew old ties, build new relationships, and develop an even stronger proactive stance to achieve a great deal more in the coming years.

Most importantly, I hope that we cut through our respective disciplines and experiences with a sharply honed, common goal: to come away from this conference with a strategic plan of action that is inspired, yet realistic.

We are in need of a plan of action that can dramatically save the lives of millions of Americans—especially our youth—by helping them make informed decisions to avoid the risks and hazards of tobacco use.

We are in need of a plan of action that can speak for our younger children—who have *no say* and *no choice* regarding exposure to secondhand smoke —whose resulting health problems, ranging from watery eyes and runny noses to asthma and pneumonia, are not for them to inherit—because of an adult's pleasure.

Let me tell you what stands out most in my mind as we cut through talk and get down to action—as we really spell out what we all can do to make our goals a reality.

The Challenges Ahead

I call them the Surgeon General's ten challenges for tobacco control, because colleagues, the time to act is *now*, there is a generation at risk.

Challenge 1

The first challenge is to use our voice clearly, collectively, and assertively. Let's speak in *one voice* to broadcast our messages loud and clear. Messages that say:

- Smoking is the single most preventable cause of death in our society—and it is costing this Nation plenty—52 billion dollars per year, a billion dollars per week.
- That tobacco is the only product that when used as directed—results in death and disability.
- That it is never too late to quit!
- And that prevention does, indeed, work! But we must all get involved and work together to prevent this needless loss of human life.

Let's remind the public that we're talking about something quite devastating: *the premature deaths of nearly one half million people every year in this country alone.*

That's tantamount to wiping out the population of Boston in one year, Seattle the next, Nashville/Davidson the next, and El Paso the year after that —

Or, put another way, the annual number of premature deaths due to smoking is equal to three fully-loaded jumbo jets crashing and killing everyone on board every single day of the year!

Think about it! Half a million needless deaths —and all of them preventable.

Challenge 2

The second challenge is to expose the seduction of our children by the tobacco industry—and to work proactively to counter their effective message and techniques.

After all, the tobacco industry must replenish the half million smokers who die each year from smoking-related disease and the one million who quit. What better replacement than those with young, impressionable minds?

The sobering facts concerning tobacco and youth speak for themselves:

We know that:

- Ten percent of these smokers begin smoking by the fourth grade, and by the 10th grade, nearly two-thirds have initiated smoking.
- And, 90 percent of smokers begin smoking before the age of 21—75 percent do so before 18, the legal age to purchase tobacco in most States. And by the time they realize it, 90 percent are hooked on nicotine.
- We estimate that if 20 million of the 70 million children now living in the U.S. will smoke cigarettes as adults—at least 5 million of them will die of smoking-related diseases.

We know from years of research that the majority of children who smoke are from homes where one or both parents smoke. And that the earlier they start smoking, the greater their risk of lung cancer, heart disease, chronic lung disease, and a wide range of other smoking-related health conditions.

- We also know that three in four teenagers who smoke make at least one attempt to quit—but are unsuccessful—underscoring the powerful addiction of nicotine.
- Nevertheless, the tobacco industry spends a staggering $4 billion each year on cigarette advertising and promotion. And each year, the tobacco industry garners $221 million in profits from illegal sales of tobacco to children. And each year, the industry tells us that they advertise only to promote brand loyalty!

We know better. We know that cigarette marketing takes on a wide variety of activities and distribution of goods that appeal to our kids. Youth-oriented events, displays at sporting events, and the distribution of promotional items such as T-shirts, posters, and caps—these are typical of such marketing schemes all around the country.

I am deeply concerned that many young people are lured to these activities and start smoking and using tobacco as a result of these aggressive marketing ploys.

As a Nation, I believe we are not doing our part in tobacco control by failing to insist that the tobacco industry become more socially responsible.

I recognize the power of a free market and the importance of advertising to make such a market operate successfully. However, when advertisements portray a dangerous habit like smoking as an exciting, youthful, and healthy activity, such advertisements do not honestly represent the real-life consequences of tobacco.

We must then reevaluate the distribution, sale, and advertisement of such products if we are indeed to protect the public, especially the health of our children.

The "seduction of children" by advertising will always remain a hotly controversial issue—but we cannot let that intimidate us or halt our progress in developing effective prevention programs, or in speaking our minds. After all, the First Amendment was created for *all* Americans.

Last year, as you know, I joined my colleagues at the American Medical Association in calling for R.J. Reynolds Tobacco Company to voluntarily withdraw its Joe Camel advertising campaign—a campaign that shamelessly appeals to children through the use of one of the most widely recognized cartoon characters among young children today.

If the tobacco industry really wanted to be responsible in its advertising practices, it would voluntarily have taken steps to limit such advertisements among young people. It would have played a truly supportive role in helping to educate our youth about the dangers of tobacco.

But these are only pipe dreams.

Because the bottom line is, that, for the tobacco industry, profit speaks louder than ethics.

Colleagues, *our bottom line* is this: we have had enough irresponsibility and hypocrisy. Enough of hiding the truth behind a lot of smoke and mirrors.

- We absolutely cannot let the tobacco industry continue to target our children with false messages regarding smoking.
- We absolutely cannot let the industry dictate who the next smoker will be.
- We absolutely cannot let the tobacco industry continue to put their profit agenda ahead of our Healthy People 2000 agenda.

We know better ... and we must act, NOW.

Challenge 3

The third challenge is to speak out against the seduction of women by the tobacco industry and develop effective prevention messages to counter the industry's misleading enticements.

To the average American, the slogan "you've come a long way baby" is just an advertising ploy, but to those concerned about the dangers of tobacco, the meaning is more serious and goes much deeper than that.

The women of this country are continuously being exposed to numerous advertising messages that subtly encourage them to begin a lifelong, often deadly addiction to smoking—an addiction that was not present in US women prior to 1900.

Today, in this country there are 22 million women smokers. I would say that's a pretty big special interest market.

Women's magazines are flooded with ads for tobacco products, while very little coverage is given to the dangers and negative consequences of smoking. Unfortunately, the so-called enticing "benefits" of tobacco products—everything from a glamorous social life to weight loss—have very little to do with the real-life consequences: cancer of the lung, cancer of the cervix, and cancer of the bladder—not to mention wrinkles, premature aging, and ulcer aggravation.

As a result of this widespread, seductive courting by the tobacco industry, lung cancer deaths in women have surpassed deaths caused by breast cancer.

- About 46,000 women die from breast cancer every year, while 53,000 women are estimated to have died from lung cancer in 1992—equivalent to the entire student body of Ohio State, or the combined number of employees in the Department of Health and the Department of Justice in the Washington Metropolitan area.

Women who smoke are also at a higher risk for cancer of the uterine cervix than women who do not smoke, not to mention the short- and long-term consequences of low birth weight in their children. (Maternal smoking accounts for 3,500 infant deaths each year.)

In addition, women who smoke cigarettes and use oral contraceptives are 10 times more likely to suffer heart attacks, compared with those who do not use either product.

Something else that worries me tremendously is that more and more *young women* are beginning to smoke—in fact, cigarette smoking prevalence among adolescents is about equal for both males and females—between 18 and 19 percent.

And the smoking prevalence rates among adult women are predicted to eventually reach those of adult men.

It may be a harsh sentence, but women who smoke like men are predestined to die like men.

We owe it to all the women in our lives to see to it that Virginia Slims women *do not* follow in the tragic steps of the Marlboro man—but down a path that will lead to greater health and fulfillment.

Challenge 4

The fourth challenge is to spur federal, State and local legislative action for tobacco control that will have meaningful, long-lasting impacts. We cannot remind the public often enough that the sale of tobacco to those under the age of 18 is illegal in 47 States—and I, for one, would love to see that number go to 50—but most importantly, enforced!

Let me remind you of the facts about minors' access:

- Each year, more than three million American children under the age of 18 consume 947 million packs of cigarettes. So, when I say 'where there's smoke —there's children,' I'm dead serious!
- A recent study by CDC found that there are currently 2.6 million youths 12-17 years of age who smoke—1.5 million of whom usually buy their own cigarettes.
- Eighty-five percent of youths 12-17 years of age buy cigarettes at convenience stores and gas stations, 50 percent buy cigarettes from large stores, and 15 percent buy cigarettes from vending machines.

In short, our children can purchase tobacco practically wherever and whenever they want—many local jurisdictions realize this and want to do something about it.

A new report, *Youth Access to Tobacco*, prepared by the Office of the Inspector General, found that all but three States ban the sale of tobacco to minors under the age of 18, but in many States there

is a serious problem of enforcing the laws. *In fact only two States,—Florida and Vermont—are actively enforcing their minors' access to tobacco laws statewide!*

A new Federal law, the ADAMHA Reorganization Act, will assist in curbing tobacco sales to minors if properly enforced by the States. The new law will require States to ban the sale and distribution of tobacco to anyone under the age of 18 by October 1, 1994.

In response to this problem, The Department of Health and Human Services developed a model bill two years ago to encourage the active enforcement of strong laws against selling and promoting tobacco products to youth—and urged the Governor of every State to adopt it.

Colleagues, my true concern is that that we simply cannot have a double standard for alcohol and tobacco—two of the most addictive drugs available in our society. The public and the policy–makers alike must come to view the sale of tobacco to minors as critically as the sale of alcohol or other hazardous substances.

States must take a more active lead in requiring identification when selling tobacco to minors.

And responsible businesses, all stores and all other retail outlets that sell tobacco should voluntarily act and prohibit sales of tobacco to minors—whether or not there is a law, whether or not the laws are being enforced.

We simply cannot afford to lose ground in these areas. We must become partners with legislators, policymakers, and other State and local officials to ensure that the "long arm of the law" does, indeed, reach out, swiftly, and consistently, to prevent our young people from beginning a lifetime of addiction.

Challenge 5

The Fifth challenge concerns the dangers of environmental tobacco smoke (ETS), more commonly known as a secondhand or passive smoke. As the press events of the last week have conveyed, we must continue to bring the facts about the dangers of secondhand smoke to the attention of the public.

Seventy-five percent of our citizens don't smoke—they should not have to endure the consequences of the smoke of others. We must help make that a reality.

EPA's designation of ETS as a Group A human carcinogen will be the catalyst for strengthening regulations to protect the public's health by controlling smoking in public places.

Above all, let us not forget the health hazards of ETS on our children—our most valuable, yet our most vulnerable.

Last week's dramatic developments must galvanize all of us in the health community to spread the word far and wide—to our patients, our families, our schools, businesses—and throughout our community: *the consequences of secondhand smoke affect us all.*

Now, more than ever, let us not remain second-hand victims, but become the sure victors—through first hand prevention.

Challenge 6

The sixth challenge has to do with addressing another serious problem that threatens the health and well being of our youth—the widespread use of smokeless or "spit" tobacco.

In recent years we have witnesses an upward trend in young people who begin to use tobacco in a different way. But tobacco is tobacco is tobacco—no matter if you chew it, smoke it, or spit it.

I am deeply concerned by the attempts of the spit tobacco industry to downplay the health hazards posed by this type of tobacco.

Last month I released two special reports, one prepared for me by the HHS Office of the Inspector General and the other from the National Cancer Institute. The reports contain some alarming conclusions about the use of smokeless tobacco by American youth.

We found that:

- In recent years, the use of spit tobacco by our young people has rapidly climbed to very high levels, with youngsters' use of "moist snuff" tripling in five years. The spit tobacco industry spends nearly half of its 100 million advertising budget on promotions and sponsorship of this product.

- In some areas, the use of spit tobacco is well established by kindergarten!

- Contrary to what many would have us believe, spit tobacco use by our young people is not confined to only one region or population group. It is not a Southern problem, or a white male problem—it is an American problem!

- In 1991, about 7 million persons 12 years of age and over used spit tobacco in the U.S.—the majority of them, young males—who most likely do not understand that spit tobacco is NOT a safe alternative to cigarettes—despite our warnings.

Spit tobacco is as addictive as cigarettes—after all, nicotine is nicotine. In the short term, spit tobacco causes serious health effects. Leukoplakia, gum recession, tooth loss, coronary artery disease, and total toxicity for pregnant women, are all short term consequences.

In the long term, spit tobacco can be deadly. There is a definite relationship between prolonged spit tobacco use and oral cancer. About 75 percent of oral and pharyngeal cancers are attributed to smoked and spit tobacco. Sadly, the relative survival rates for these cancers are among the lowest of the major cancers.

The majority of our experts predict an oral cancer epidemic beginning two to three decades from now if the current trends in spit tobacco use continue. Let me remind you that this is an epidemic in which *our* children will be the victims.

Challenge 7

The seventh challenge is to develop our strategies and action plans in close coordination with the Department of Health and Human Services' Year 2000 Objectives.

These objectives give us a blueprint, or roadmap, if you will, of what direction—as a Nation, State, or community—we must take to improve the health and wellbeing of our society.

To the degree we use these objectives as a rallying point in our tobacco control efforts, we will be more focused and cohesive.

For example, one of the key objectives of the Year 2000 Report is to remove the appeal that tobacco advertising has upon young people.

As you know, for years now, ads for cigarettes and smokeless tobacco have been banned on television and radio. In addition, a number of sports facilities nationwide regulate tobacco advertisements. However, as I have mentioned, the public—particularly children, are still exposed to tobacco images and advertisements everywhere.

Let's take the Objectives to heart—by continuing to build coalitions and partnerships at the local, State and federal levels that are dedicated to restricting or eliminating tobacco promotions to underage youth.

And let me reiterate that to protect children from becoming regular smokers, we must strive, not only to enact minors' access laws in all 50 States prohibiting the sale of tobacco products to minors, but to see to it that the laws *must* be enforced to be of any value.

In addition, we must continue to speak out to ensure that our children receive tobacco and health education and prevention as part of their routine health and classroom curriculum. They must understand both the serious health risks and the addictive nature of smoking and tobacco use. And they must become more savvy to advertising ploys.

Similarly, we must ensure that our children have positive and visible role models, and that school boards in every State must adopt nonsmoking policies for students and school staff alike. After all, what message does a student receive when she sees her health teacher smoking openly outside in the schoolyard?

We have a long way to go here. In 1990, less than half of the Nation's students attended smokefree schools; and less than half of our secondary schools were offering activities in tobacco-use prevention.

In order to achieve a smokefree society, all States must have plans to reduce tobacco use, especially among youth. In 1990, only 22 states had specific plans for preventing and controlling tobacco use. We absolutely need more.

Challenge 8

The next challenge has a lot to do with the way we health professionals do our work and how we contribute by virtue of our respective disciplines.

Challenge 8 is the challenge of helping to assess, document, and change society's attitudes and practices with regard to tobacco use—especially where our children our concerned.

For whether we like it or not, our children are susceptible to the allure of smoking.

Like it or not:

- Ten years from now, we will have an addicted generation.
- Twenty years from now, we will face an epidemic of lung cancer, bladder cancer, chronic lung disease, ischemic heart disease, complications of pregnancy, low birth weight, and as a consequence—an increase in infant mortality.
- Thirty years from now—and thereafter—if we do not start prevention today, we will confront a social and economic health care burden whose upward trajectory will be impossible to alter.

In light of these predictions, we need more accurate data, more ways to disseminate that information, and more ways to reach those at greatest risk.

Above all, we must improve our ability to collect information on morbidity and mortality. Information that is comprehensive, gender-specific, culturally-specific, responsible, and responsive.

Equally important, we must examine and evaluate information on the economics of the tobacco industry so as to understand the pervasive role that tobacco plays in our Nation's economy.

We must also gain a better understanding of the tools that are available to use to counteract smoking: legislation, taxation, and individual and public health education aimed at altering social norms and attitudes.

Knowledge is indeed power. If we truly wish to help others take control of their lives, we must continue to empower ourselves with new knowledge.

Challenge 9

The ninth challenge has to do with strengthening the resources we have and finding additional resources we need—to succeed in our mission to control tobacco. We might not have resources equal to the industry, but what we do have on our side, is the truth—backed by scientific integrity.

Conferences such as this are essential to tapping the knowledge and expertise of professionals from many disciplines. They give us a chance to gain new insights and perspectives, share lessons learned, galvanize leadership, and plunge ahead with greater momentum.

During these next few days, I urge you to listen carefully to one another. And do, by all means, bring, not only your intellect to these discussions, but your passion, imagination, and creativity. Without these essentials, our best laid plans with have no empathy, and our solutions will have no depth.

In finding resources, let's remember, too, that long-lasting partnerships come about in the least expected ways, from the least

expected sources. We have learned much, in prevention, about the value of public/private partnerhsips.

And those lessions can certainly be applied to alliances and collaborations among our many varied disciplines and callings.

Let's make it a point to find common ground with other professionals who have expertise in their areas of competence, at least equal to our own: teachers, nurses, technicians, engineers, pharmacists, administrators, police, lawyers, judges, legislators, public officials—and yes, even Congress.

In addition, let's now forget the value and the clout of public opinion. Their sincere sentiments and loud, vocal stances can bolster our cause and move mountains —mountains of tobacco, alcohol, or anything else for that matter!

Challenge 10

And now, for my tenth and final challenge. Let's make personal involvement our watchwords—both in prevention and control. There is an infinite amount of room on the pulpit for those who care enough to make a difference.

We know the devastating consequences that tobacco causes in our society. We know the shocking tolls of disease and death that tobacco causes. And we know the practices of the tobacco industry to promote this deadly product.

I think the time has come for us to insist that the tobacco industry be operated as responsibly as any other manufacturer of consumer products in this country.

Obviously, taking on the matter of tobacco advertising and promotion has not been a traditional role of physicians and other health professionals. However, it is so closely related to tobacco consumption that it is impossible to separate the two issues.

Physicians and other health professionals must become the champions of prevention, increasing public awareness of the issues, and promoting public action to counter the industry's daily onslaughts.

Our next generation depends on what we do now, and how well we play this game.

Conclusion

In closing, I believe that we have indeed come a long way!

- Who would have believed—40 years ago—that the 1992 Olympics in Barcelona would be smoke free?
- That Australia would join other countries and approve a ban on advertisement and promotion of tobacco products?
- That the World Bank decided that no further loans would be made for the production of tobacco?
- That smoking, chewing, and snuffing would be banned in Colonial Williamsburg, Virginia—a society portrayed as being built on tobacco trade?
- That passive tobacco smoke would be designated as a human carcinogen?

Yes, we have come a long way. Victories are occurring in this country, and in countries at every level of tobacco control sophistication.

Concerning how far we have come, it would not be presumptuous for me to say that *where there's smoke—there's prevention.*

Colleagues, as we continue to work together in the explosive new millennium ahead, we must learn from our mistakes and celebrate our successes, no matter how small. I guarantee that success will build if we persist.

But in the face of success, let's not become complacent. We must remain forever vigilant. In the future, women and children will be the largest targets for the tobacco companies—the trouble is, the future is already here!

We must work even harder to let the tobacco industry know that as long as we are around, the industry will not decide who the next smokers will be.

Thank you.

Report on the Tobacco Industry's Impact on Agriculture and Health Care Policies

Kentucky State Representative Anne Meagher Northup

Nothing has united Kentucky politicians in the past as solidly as their unequivocal support for tobacco. Republicans and Democrats, conservatives and liberals, rural Kentuckians and their urban counterparts—these men and women have been united in their fight for the rights of smokers. They argue against laws limiting children's easy access to cigarettes; they decry tobacco excise taxes (which are the second lowest in the country). In Kentucky, politicians who can agree on nothing else agree to support tobacco.

Tobacco has profoundly impacted Kentucky, especially in the areas of public health and agriculture policy. Few states have a higher percentage of smokers. It has the highest per capita consumption of cigarettes and, not surprisingly, the highest death rate associated with tobacco. It has the highest percentage of smokers in the 18-34 year-old age group, due in part to the implicit message of political and business leaders that smoking is "politically correct" in Kentucky. These new, young smokers begin smoking despite health education, frightening medical evidence—and probably the tobacco-related death of a close friend or relative.

The effect of tobacco is also felt by Kentucky's farmers. As the number one cash crop, burley tobacco will be worth more than $890 million to approximately 60,000 burley growers. Tobacco manufacturing and processing are major employers throughout the state.

Kentuckians were exposed recently to two stark reminders of their state's pro-tobacco message. First, the Council for Burley Tobacco paid for numerous billboards delivering the message that tobacco pays for college tuition, nice homes, and a higher standard of living for the people of our communities. There was nothing subtle about the implication that, without tobacco, Kentuckians would lose "the good life."

The second reminder came from U. S. Senator Wendell Ford, the Senate's Democratic Whip, who campaigned across Kentucky last year with the boast that he has smoked for 50 years without harm. In most states, politicians no longer smoke in public. They have either kicked the habit or smoke only in private. In Kentucky, however, many political leaders smoke publicly, believing it will improve their image—and their margin of victory at the polls.

The economic dependence on tobacco makes it difficult to pass any tobacco-health care legislation. The tobacco companies and the farm organizations with which they work promote the idea that any youth access bill, any increase in taxes, or any clean air measure will cause the price and demand for raw tobacco to decrease. Because the survival of so many Kentucky farmers depends on tobacco, the political strategy of establishing an inverse relationship between health legislation and tobacco markets is very effective.

While establishing the perception that health legislation will hurt the tobacco farmer may make good political sense, for the industry, it is counterproductive to understanding what has really effected the demand for tobacco. Continued smoking by Kentuckians cannot offset the national decline in the use of tobacco products. In fact, if every Kentuckian were taught to smoke in the sixth grade and became a lifelong smoker, it is unlikely that the prosperity of the tobacco farmer would improve. On the other hand, if every Kentuckian quit smoking tomorrow, there would hardly be a measurable decline in demand or price for raw tobacco because Kentucky smokers do not create the demand for tobacco, and the tobacco industry knows that.

Even if Kentucky smokers could sustain the demand for tobacco, it is important to state emphatically that economic prosperity does not justify the promotion of tobacco products, regardless of the effect on farmers. In this country, *we do not recognize death as a fair exchange for prosperity or a higher standard of living.*

At the expense of the Tobacco Institute, Price Waterhouse conducted a study which concluded that the tobacco industry provides 800,000 jobs (including production, advertising, distribution, and legal services). The Center for Disease Control states that approximately 400,000 smokers die each year as a result of their habit. This means one person must die each year to sustain two jobs. Put another way, 22 people must die to support the 44 year career of a Philip Morris employee. Surely, no one would argue that this is an acceptable trade-off. It is absurd for the tobacco industry to use lost jobs as a rationale for not saving lives.

While health legislation has to be our primary objective, the political leaders in Kentucky should be much more concerned about the future of the tobacco farmer. In the last Presidential campaign, much was said about "family values." However "family values" is defined, our farm families epitomize the best. They are hard-working, they are self-motivated, and they are self-sufficient. They are not looking for government handouts. Seeing them survive and

prosper should be a concern to us all, and an aggressive state and federal agriculture policy should reflect that concern.

Unfortunately, most politicians from Kentucky have used their clout to blindly back the tobacco industry's agenda instead of truly helping the tobacco farmer. Their gamble is that if the fortunes of the industry are good, then the farmers will also prosper. This is a rather errant assumption considering the difference in the current fortunes. The tobacco industry is experiencing rapid growth in sales and profits, while the tobacco farmers have to pray for a couple of pennies' annual increase in the price for a pound of tobacco. It is worth noting that while Kentucky's burley tobacco farmers are struggling to survive, the retiring Chairman of the Board of Philip Morris took home a whopping $26 million bonus.

As the demand for tobacco products changes, the tobacco companies have the best minds money can buy to strategically prepare them for the future. From all indications, that future does not include the majority of our tobacco farmers. What minds do the farmers have strategizing for their future?

Most farmers are beginning to realize that the strength of today's tobacco market is a result of the overseas market. As the national demand for cigarettes declined, the domestic tobacco industry began diversifying. The national companies purchased food processing and distributing companies to replace lost tobacco business. While these ventures were—and are—compatible with tobacco, they are far less profitable.

In order to develop new tobacco markets, the industry expanded overseas. The international emphasis on free trade eliminated many obstacles to these markets, especially in communist block and the Pacific-rim countries whose populations are fascinated with emulating American culture. While smoking was commonplace in these countries, it previously had not been glamorized through advertising. In these countries, adult men dominated the purchasing market, even though they consumed much less than American smokers.

The U.S. trade negotiators have been committed to opening these overseas markets. It has been correctly assumed by many Americans that this has been accomplished by lower tariffs, but the success is largely due to negotiations that have eliminated the ban on advertising. Overseas audiences are now seeing for the first time advertisements that link smoking to young, active lives. While the moral implications of this trade policy and industry initiatives are staggering, the focus of this article is: What does this trade policy mean for our farmers?

In order to open the overseas tobacco opportunities, our trade negotiators had to overcome stiff opposition to the elimination of the advertising bans. In fact, in some instances the United States threatened the most extreme measures possible (301 sanctions) in order to force countries to acquiesce to these demands. In some countries, concessions to our tobacco industry required tradeoffs by the United States in other agriculture commodities. Thus, we kicked in the door for tobacco but closed it on other opportunities such as meat products and corn.

It can be reasonably assumed that this trade-off is a direct result of the political pressure that exists in Washington. Recent reports show that the tobacco industry is one of the highest contributors to both Congressional and Presidential campaigns. Furthermore, by conveying to tobacco farmers that their futures are intrinsically linked to the Congressional delegations' commitment to tobacco, the industry insures that these politicians from tobacco states do their bidding in order to be re-elected. It is easier for senators and representatives to go along with the tobacco industry than to independently convince the farmer that some of the industry's priorities are contrary to his best interest.

Unfortunately, these new overseas markets do not mean that American farmers or production workers have new, long-range markets for tobacco. The industry has been very consistent in its reaction to these new trade opportunities. With great speed, the industry built new plants, purchased existing plants, or formed joint venture with overseas companies. They have outfitted these facilities with state-of-the-art equipment and are prepared to manufacture "American" cigarettes in the overseas backyards of their new customers.

The industry has invested millions to find new sources for high quality, lower cost tobacco. Since tobacco farming is heavily labor intensive, American tobacco farmers cannot possibly match the price of high quality tobacco from Brazil, Argentina, or Mexico. In 1991, the average price paid for Kentucky-grown burley was $1.75 per pound, while Argentinean burley of similar quality was purchased for $0.46 per pound. The pattern of the tobacco companies' investments leads us to believe that they intend to supply their ever-expanding cigarette markets and new customers with tobacco grown outside the United States. It is ironic that the United States ignored moral inhibitions and used its trade clout to open foreign markets for companies whose strategies will not benefit American tobacco farmers or production workers.

In the short run, these new foreign markets have provided Kentucky tobacco farmers with a window of opportunity. Until overseas production could meet demand, our farmers enjoyed new and higher quotas that exceeded their ability to grow. The price rose steadily, giving our farmers a false sense of security. Now that window is about to close. The quota that each farmer can grow will be reduced by 10 percent—the maximum drop allowed—next year. After 1993, there is no limit on how much it can be reduced each year. Many predict that it will fall 50% in three to five years. Furthermore, as more foreign tobacco is imported, there will be less pressure on the industry to raise the bid price each year.

Tobacco farmers have been told by the industry for years that foreign leafs could not match Kentucky quality. For that reason, the recent expansion in the market has encouraged farmers to invest in new barns, equipment, and a larger tobacco base. By failing to warn these farmers of the precarious future of tobacco, the industry and supportive political leaders have allowed such investments to further jeopardize our farmers.

Kentucky is full of leaders that excuse their failure to develop any viable alternatives by claiming that there is no other crop that can replace tobacco income—which is currently true. It will continue to be true if no new initiatives are begun. Our very inaction insures that there will continue to be an absence of viable alternatives. Make no mistake: The rocky, hilly terrain and the small size of many tobacco farms make it especially difficult to develop alternatives. It is frustrating that it is the very people who represent farmers—the same ones who act as though the situation is hopeless—who are failing to address the issue with any foresight. Since the fortunes of the tobacco industry and the fortunes of the tobacco farmers are no longer the same, it is time to ask the leaders in Kentucky whose interests they represent, the tobacco industry or the tobacco farmer? State agriculture programs must be adapted to deal with the obstacles to new crops. Rather than looking for "alternative" crops to replace tobacco, we should be thinking of "supplemental" crops while tobacco can still support the farm. The purpose is to make non-tobacco acreage more profitable. Distribution systems to help compensate for small farms, careful crop selection to overcome terrain and land problems, and food processing plants to raise the value of local products are worthy approaches. The cigarette tax could be raised and dedicated to provide grants and low-interest loans to individual farmers for new farm equipment, irrigation systems, and industrial bonds to food processing and other non-tobacco companies. This has the double benefit of raising the price of cigarettes to discourage use and could eliminate the usual source of political opposition in southern states to an excise tax on tobacco products.

The tobacco industry could help. Since they have diversified, they own a wide variety of food processing companies. It is not unreasonable for the tobacco industry to locate its food processing plants in our rural communities, nearer to the tobacco farmers that provided the companies with their profits all these years. These processing plants help ensure that crops grown to supply the plants would bring higher prices.

The tobacco companies should at least be asked publicly the questions about investment so that it will be clear as to where their loyalty and appreciation lie and to determine if they feel any responsibility to help in a transition if they no longer need such large quantities of tobacco from Kentucky farmers.

Since I first became involved with the question of health and tobacco, I have discussed the concerns of the tobacco farmer. While maybe reluctant at first, the health organizations today in Kentucky are a well-informed force advocating for these farmers. These organizations watch for new quota levels and overseas purchase totals almost as much as health statistics. It is ironic that those who are seen as the opponent of the tobacco farmer are today his best and most public advocate.

Tobacco Use: An American Crisis

Remarks of the Honorable Henry A. Waxman

Today you will not hear a traditional Washington speech. I didn't want to come here to tell you what you already know, or only what you want to hear. I want to tell you what you're up against when you challenge the tobacco industry in Washington and how you can become more effective.

The timing for your conference coincides with the EPA's recently released report on the adverse health effects of environmental tobacco smoke or "ETS."

The report declares tobacco smoke a Class A human carcinogen. Not since release of Surgeon General Luther Terry's landmark report on lung cancer almost 30 years ago has the public health community had a scientific weapon of such profound and long-term importance. The government has now made official what we've suspected for years: Smoking exposes *nonsmokers* to an increased and significant risk of disease.

The report provides a solid scientific basis for Federal, State, and local governments to move beyond current ETS restrictions to eliminate the risk of secondhand smoke in the workplace and public facilities. The report is a clarion call to ban smoking, for example, from all Federally funded facilities that provide childcare services or which provide care to pregnant women. The evidence of increased risk of sudden infant death should help persuade the smoking parents of newborns to quit—if not for their own health, then for the health of their children.

The election of Bill Clinton has assured that the health care needs of children will be a top priority in Congress. The EPA's documentation of increased risk to children from tobacco smoke should be used to integrate tobacco control into a national child health agenda.

The EPA report underscores the inherent danger that tobacco poses to smokers and nonsmokers but also calls attention to the inherent evil of the industry that promotes the addiction of children and costs the health care system $50 billion annually.

In fact, until we better control tobacco use, it will be difficult to control medical costs. Tobacco use represents the single most preventable factor in the rising cost of health care. Raising the excise tax on tobacco will be vital to raising the revenue necessary to finance the health reform proposals under discussion in Congress. Higher taxes are also the most effective means we know of to reduce tobacco consumption by children.

None of you should be surprised to learn that as the number of tobacco deaths and disabilities rise, tobacco industry expenditures for advertising, promotion and lobbyists increase. You also know that it is becoming increasingly difficult to promote public health policies in the face of such enormous economic power. The tobacco companies are little more than nicotine pushers in expensive suits. Philip Morris, RJ Reynolds and US Tobacco spend $4 billion a year selling their addictive product for the same reason Columbian drug lords traffic in cocaine: It pays.

If not for the money, they wouldn't hire top legal talent in Washington and in every State capital to block increases in excise taxes, to defeat restrictions on advertising and evade tobacco control laws. If not for the money, they wouldn't beguile our children with cartoon characters like "Cancer Joe." If not for the money, they wouldn't put so much creative effort into targeting our minority communities for sales of an addictive and life-threatening poison. If not for the money, lung cancer wouldn't be the leading cause of cancer death among women.

During President-Elect Clinton's campaign, a much talked about sign in the headquarters reminded workers and the candidate "The Economy, Stupid." The sign spoke about the need to focus. Keeping on your message was obviously good advice for a campaign challenging an incumbent President. It is also good advice for going up against the tobacco industry, which seeks incumbency status in every administration.

I want us to have a sign, too. It would read "The Children, Stupid." It may already hang in the tobacco industry offices. Children should become *our* focus. Our success will be determined, politically and medically, by how rigorously we hone legislative efforts to that message.

The Surgeon General warned you on Sunday that wherever there is smoke, there are children. Children should be our priority because they are the tobacco industry's priority. Children are the industry's replacement smokers. Adults don't start smoking—children do.

If we can protect our young people from nicotine addiction, they are unlikely to die of smoking-related diseases as adults.

And, let us not forget, the use of tobacco products by children is dangerous and it is illegal.

Last year Congress passed the "Synar Amendment" which broke new ground by linking tobacco control with the "War on Drugs." For the first time, all drug abuse prevention programs must include anti-tobacco strategies. More importantly, each of our 50 States must enact *and effectively enforce* tobacco control laws as a condition of receiving $1 billion in Federal substance abuse treatment and prevention funding.

It is a powerful incentive. Failure to adequately enforce tobacco control laws can now cost States hundreds of millions in Federal funding. Full implementation of the Synar Amendment is the single most important tobacco control initiative we can address this year. The extent to which you and your organization can use this new law to persuade or compel State and local enforcement activities will be a measure of both our effectiveness and commitment to curtailing youth access. The tobacco industry is busy weaving a web of apathy and fear within the agencies to weaken this law. They must not succeed.

The inauguration of a new Administration is heartening. Despite the rhetoric that we heard from Dr. Sullivan during the Bush years, no legislative proposals relating to tobacco control were submitted or endorsed. We are optimistic that President Clinton and his health officials will approach tobacco control as a serious and life-threatening public health problem that requires more than talk.

As we look toward the new Congress, several initiatives are under consideration:

Warning label reform

The EPA report and a growing body of scientific evidence about the addictive nature of nicotine underscore the urgency to revise the mandated health warnings. It's time the warnings spoke to the addictive nature of nicotine. It's time the labels warned that environmental tobacco smoke can kill nonsmokers.

It's time U.S. warnings were equal in size and prominence to those on tobacco products sold in Canada. We need larger warnings, unambiguous warnings, warnings of effect and substance. It's also time to take on the billboard industry. We must put an end to the special treatment tobacco billboards enjoy.

Federal health warnings on billboards are virtually invisible and ineffective. Billboard reform would require that the health warning be no smaller than the company's brand name. Frankly, with your support we should simplify the warning and require a skull and crossbones on every tobacco billboard.

Advertising and Promotion

The tobacco industry first told us tobacco didn't cause death and disability. Then they told us advertising didn't cause smoking. In past years we have attempted to enact legislation to limit the industry to tombstone advertising. They have successfully resisted these proposals.

A total ban is ideal. Tombstone advertising is justified. Changing the tax deductible status of advertising would be helpful. But it's time to consider proposals for other, perhaps more narrow forms of advertising restrictions. We are considering proposals to prohibit specific forms of advertising which have a demonstrated appeal to youth.

Regulation

Ironically, tobacco products are among the most under-regulated consumer products. But the Executive branch has far more authority to regulate tobacco than it is now using.

The authority to regulate deceptive or unfair advertising lies with the Federal Trade Commission, and they could do more. The authority to get cigarette sponsorship of sport off television broadcasts rests with the Department of Justice, and they could do more. The responsibility to regulate implied health claims—such as those for low tar cigarettes—rests with the Food and Drug Administration, and they too could do more.

We must work together to hold enforcement and regulatory agencies accountable for their actions or lack of action. The inauguration of a new Administration provides a good opportunity to put tobacco control back on the regulatory agenda. I would like to make this effort before we attempt to enact legislation to expand the jurisdiction of regulatory agencies over tobacco products.

Tobacco Exports

One of the most shameful legacies of Bush Administration health policy was the failure of their health officials to contest trade practices that promoted the addiction of Third World consumers to tobacco. The sale of U.S. tobacco to the Third World is a trade issue, but that is not the question. The sale and promotion of an inherently lethal product is unethical. The immorality of such practices cannot be dismissed simply because its victims are not U.S. citizens.

It would be ironic if the humanitarian instinct that sent U.S. troops to Somalia resulted in expanding the promotion of tobacco products to its suffering people.

We can do better. It is our responsibility as Americans. The promotion of public health has no borders. Caring is not limited by nationality.

Let's change how we do business.

We all want the tobacco industry to change how they do business.

If we are to achieve this goal, the public health community must also change the way it does business. Unless anti-tobacco organizations can channel the good will and public credibility of this movement into political action, the industry will parry our attacks, and emerge unscathed and profitable from each encounter.

If you are to be effective, it requires serious efforts to persuade and cajole Senators and Members of Congress to your cause. It requires you to identify key political and financial supporters in their districts who share your convictions. This is hard work. It's quiet work. But the tobacco industry repeatedly demonstrates that when done correctly, it can be very effective.

I'm here to tell you that campaign contributions seldom outweigh effective grassroots organizing. Unfortunately, grassroot lobbying is hard work. Start now. Recruit constituents of like mind. Recruit students at local high schools. Recruit local reporters. Try to follow the example of anti-tobacco organizations in England that establish PAT groups, "Parents Against Tobacco", in the districts of Members of Parliament. Give Members a reason to worry about the political *risk* of supporting the tobacco industry. Currently members worry about the risk of *not* supporting the industry. This is advice the tobacco industry would prefer you didn't heed. In fact, they're banking on it.

In the 103rd Congress, the unprecedented number of new members creates great opportunities. I assure you that the tobacco industry knows a great deal about the new members of the Subcommittee on Health, and you should too. If we are going to succeed in passing new legislation we need allies. Take the initiative to meet members in their districts and enlist them in the anti-tobacco cause.

I also want to suggest that increased efforts be placed on promoting pro-health, paid advertising and promotion campaigns such as those pioneered in Australia and adopted in the U.S. by the health departments of California, Michigan and New York City. We must seize the initiative and promote a smokefree society using the same advertising and promotional tactics the tobacco industry has used so effectively.

So I leave you and your organizations with a challenge to become more effective. This conference is a beginning. You are talking together and forming alliances with organizations who have previously not been involved in the tobacco wars.

Let us resolve to succeed by becoming creative advocates. Become involved in the political process and remember what former Speaker Tip O'Neil always said: "Politics is local." And remember, always remember why we are here: "The Children, Stupid." Focus your efforts upon the mission of protecting the young from a lifelong and lifethreatening addiction. Finally, work at the grassroots to creatively use the promotional tactics of the industry to sell a positive message of health and independence from nicotine.

I stand ready to help you and accept nothing short of success.

Women, Girls and Tobacco

Michele Bloch, MD, PhD
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Introduction

Tobacco use by women and girls constitutes one of the most important and urgent challenges to our nation's public health. Half of the world's female deaths from tobacco induced diseases occur in the United States. It is projected that by 1995, 240,000 American women will die prematurely because of tobacco, each year.

Women's and girls' use of tobacco may be explained by a variety of factors. Foremost among these is the tobacco industry's efforts to promote smoking among women and girls. Individual motivators, including psychosocial factors and nicotine addiction, also influence girls to start and to keep smoking. Additionally, the absence of a nationally coordinated strategy makes prevention and cessation of tobacco use for women and girls more difficult. These factors reflect women's lower social, economic and political status in American society. To successfully diminish tobacco's toll on American women and girls, these issues must be recognized and rectified.

The Health Hazards of Smoking for Women and Girls

Smoking has been declining slowly among both men and women (Fig. 1). However, smoking among men has been declining since the 1950s, whereas the prevalence among women began to decline only after 1977. The Centers for Disease Control and Prevention reports that in 1990 22.8% of women and 28.4% of men were smokers. White women smoked at a higher rate than black women (23.5% vs. 21.2%), and women of Non-Hispanic women at a higher rate than those of Hispanic origin (23.4% vs. 16.3%). Among both men and women, tobacco use is sharply circumscribed by level of education. In 1990, 12.3% of women with college diplomas smoked, as compared with 27.1% of women who had not completed high school. It is projected that tobacco use will continue to decline. If current trends continue, however, the decline will occur far faster among educated Americans.

In light of the well-documented health hazards, the fact that young people continue to start smoking is extremely distressing. Smoking initiation occurs almost entirely during the teenage years, and the age of initiation has been dropping, especially among girls. It is estimated that 3000 children begin smoking each day, and for each year between 1977 and 1989, girls initiated smoking at a greater rate than boys (Fig. 2). Recently, girls' initiation rate has dropped to that of boys, although both remain unacceptably high. In 1990, 19% of male and female high school seniors were daily smokers.

For both men and women, the health consequences of tobacco use are common and devastating. They include a dramatically increased risk of lung and other cancers, cardiovascular disease, pulmonary diseases, and a host of other serious, often lethal, conditions. Lung cancer deaths in women have risen dramatically; in 1987 lung cancer surpassed breast cancer as the leading cancer killer of women (Fig 3). In addition, female smokers incur other risks, including an increased incidence of cardiovascular disease among smokers who use oral contraceptives, an increased risk of cervical cancer, and an increase risk of osteoporosis.

Smoking during pregnancy can endanger the life and health of the fetus. Studies have shown a 25 to 50 percent higher rate of fetal and infant deaths among women who smoke, often the result of preterm delivery and/or low birthweight attributed to smoking. Smoking has also been linked to Sudden Infant Death Syndrome. Despite these risks, it is estimated that one out of five pregnant women smokes throughout her pregnancy. Once again, educational attainment is the critical predictor of smoking during pregnancy: in 1989, the prevalence of smoking among college educated pregnant women was 5%, while that among pregnant women without a high school diploma was 42%.

Environmental Tobacco Smoke (ETS), also termed second hand or passive smoking, was recently declared a "Group A" carcinogen by the U.S. Environmental Protection Agency. ETS is one of the most widespread and hazardous indoor air pollutants, and many women are exposed to ETS in the home and/or the workplace. Women disproportionately occupy lower status jobs, and are thus less able to control their work environment. Researchers in California found that waitresses, who often face serious ETS exposure, have the highest mortality rate of any predominantly female occupation. They also demonstrated a four-fold increase in lung cancer mortality among waitresses, as compared with other women.

Because of the hazard of ETS, people who smoke jeopardize the health of the adults and children around them. However, women are often the primary care-takers of young children, whether in the home or in other settings, and are also disproportionately involved in the care of elderly relatives. Therefore, smoking by

women can have a serious impact on the health of those in their care, particularly, young children.

Why Do Women and Girls Smoke?

Initiation

Girls start smoking because of a mixture of individual and social motivations. Some of the personal factors which are predictors of a girl's decision to smoke are having low self-esteem, making attempts at weight control and appetite suppression, and having less knowledge and positive attitudes about smoking. Socio-cultural factors also influence whether or not a girl will smoke, for example, the degree of social acceptability of smoking, and whether siblings, peers and/or parents smoke. Teenagers, both boys and girls, are much more likely to smoke if either older siblings or close friends smoke. Parental smoking also increases the likelihood of teen smoking.

Additionally, environmental factors have a tremendous influence on girls' smoking. Attractive and manipulative advertising and promotions create positive images and reminders of smoking. Ready access to and affordability of cigarettes also encourage teen smoking. Clean indoor air policies, on the other hand, decrease smoking. Such environmental factors also influence how tobacco use is viewed by society, and thus influence individual behavior.

Maintenance

As with initiation, women continue to smoke because of a complex interplay of individual and psychosocial factors. Continued smoking is often the result of a women's physiological addiction to nicotine and her dependence on smoking as method of weight control. Additionally, there are intricate and subtle reasons why women continue to smoke which are psychological and social in nature.

Research shows that women often smoke in response to negative life experiences. Often, these experiences are indicative of the lower status and roles women hold in society. Although both men and women may smoke to reduce stress, they experience different stressors in their lives. For example, in recent years, women have entered the workforce in large numbers, but these women still shoulder the majority of child, elder, and household responsibilities. These multiple workloads may contribute to women's smoking.

Women in the workforce often hold lower-level service or manufacturing jobs, which provide little sense of autonomy or control. Both of these factors have been shown to increase stress. Indeed, women who hold jobs filled with routine or repetitive tasks often view a "smoking-break" as a welcome rest from routine. Similarly women caring for children may view cigarettes as a means to gain some "space" or personal time.

Women also smoke to control their emotions, particularly to suppress anger. In general, it is not acceptable for women to display excessive amounts of anger and hostility, or physical violence. Women use smoking to temper these emotions, to better fit the societal norm.

Traditionally, our culture praises and rewards women for their beauty, currently defined for most women, as youthful and thin. Unfortunately, many women strive for the cultural ideal, regardless of the cost to their health. Women more often the men, use smoking as a mechanism to attain and maintain ideal body weight.

Childbearing, biologically unique to women, and childrearing and caregiving, traditionally performed by women, are not highly esteemed by Western society. Nonetheless, most women will devote a portion of their lives to these activities. Many believe that time spent in these activities contributes to women's lower self-esteem. Low self-esteem takes a significant toll on women's lives; it undermines their self confidence, causes them to aspire to less than they are capable of and renders them more susceptible to societal pressures, such as pressure to smoke.

Some have argued that male-dominated societies benefit from and may contribute to women's smoking, because smoking serves to placate women. Lorraine Greaves, at the First International Conference on Women and Smoking, in Newcastle, Northern Ireland, said, "[i]f smoking can increase women's passivity and compliance, and reduce women's...emotional expressiveness, then women's smoking is of great use to society."

The factors which contribute to women's maintenance of smoking are indicative of women's lower status in society and the inequalities women often face. For despite significant gains, it is men who hold the lion's share of economic, social, and political power. The often unequal treatment of women in society must be considered when planning interventions to impact upon women's smoking. As the Canadian background paper on Women and Tobacco states:

"...women must be seen...distinct from men with respect to their social status. Unless this principle is understood, an understanding of why women continue to smoke and resist quitting smoking will remain incomplete."

How the Tobacco Industry Targets Women and Girls

Advertising

Advertising and promotion are critically important mechanisms by which the tobacco industry targets women and girls to smoke. Each year, the tobacco industry spends nearly 4 billion dollars to advertise and promote tobacco products. Tobacco advertisements are widespread in magazines, newspapers, billboards, and point of purchase displays; increasingly they are sent by direct mail. Tobacco advertisements are prohibited by law from being broadcast on television and radio. However, the spirit if not the letter of the law is frequently violated when tobacco advertisements are televised via tobacco company sponsorship of sporting events.

The tobacco industry has introduced many "women's brands", although the vast majority of women smoke mainstream brands, such as Marlboro. However, the role of "women's brands" to promote smoking among women is far more important than these brand's market share statistics would suggest. Mainstream brands

can not carry messages appealing specifically to women and girls without endangering the loyalty of their male customers. Women's brands function to carry messages to appeal to women and girls, and thus create a milieu favoring smoking of both mainstream and "women's brands."

Of the many themes used to target women and girls, two are particularly important: appeals to independence and weight control. Virginia Slims, the oldest and best selling women's brand has long appealed to women with the tagline, "You've come a long way baby." In doing so, it has attempted to link smoking with women's social progress and emancipation. In reality, however, the Virginia Slims campaign is condescending to women; for example, few women enjoy being referred to as "baby".

Similarly, many women's brands use code words for weight control, such as thin, slim, superslim, and long. These "diet terms" are extremely effective in luring women to smoke because of the strong societal pressure to be thin experienced by many women and girls. Indeed, many girls report initiating smoking to help "manage" their weight, and fear of weight gain deters many women from quitting smoking.

Advertising has several direct effects, including the ability to lure new smokers, virtually all of whom are youth. Advertising is also believed to make quitting more difficult and to encourage relapse among former smokers, by constantly presenting the public with images of cigarettes or of people smoking.

Advertising also exerts a powerful hold over the media's representation of smoking and health. Research has documented that publications which accept tobacco advertisements do not adequately report on the health hazards of tobacco, to avoid offending tobacco advertisers. This phenomena—termed media self-censorship—is particularly evident in women's magazines. As an example, not a single major women's magazine covered the release of the landmark 1980 U.S. Surgeon General's Report, devoted entirely to the health hazards of tobacco for women. Self-censorship on the part of the media is in part responsible for the public's ignorance of the depth and magnitude of both the health hazards of tobacco, and the political and economic clout of the tobacco industry.

Promotion and Sponsorship

In recent years, the tobacco industry has devoted an increasing part of its marketing budget to promotion, including sponsorship of community events and organizations. Some promotions are extremely visible to the public, for example, Philip Morris's long-standing sponsorship of women's tennis through Virginia Slims cigarettes.

Other promotions are less visible, but no less important. For decades, the tobacco industry has cultivated relationships with women's political and leadership organizations, through generous donations to general funds, programs, research projects, awards, and individual events. Sponsorship serves to portray the tobacco industry as a friend and benefactor of women, and a good "corporate citizen." The success of this strategy is due in no small measure to the modest funding base of most women's organizations, the lack of alternative corporate and philanthropic support, and the loyalty to an industry which has long supported the women's movement. This loyalty was expressed recently by the executive director of a major women's organization:

"Philip Morris is probably the first corporate contributor that [our organization] ever had...Politics is about taking care of the people who have been with you since the beginning, and they have."

The current system of campaign financing leaves politicians vulnerable to a wide variety of corporate and other interests. The tobacco industry, like many other groups, has sought to influence political leaders, both men and women, at the state and federal level. Many believe that the tobacco industry has successfully silenced many politicians, including many women's political leaders. However, there are several female state legislators who have taken bold action on tobacco issues, for example Anne Northup (Dem.–KY), Anne Siebert (Dem.–VT), and Diane Watson (Dem.–CA). These women deserve high praise for their progressive leadership.

International Sales

The tobacco industry has increased its attention to expanding overseas, and there is grave concern that the industry has targeted women and girls as a "growth market" for cigarettes. In particular, the industry has targeted women in countries where disposable income is rising. In the past, the industry's effort has been strongly supported by the U.S. government, in order to promote a positive trade balance. Along with its smoother tasting cigarettes, the industry has brought slick advertising and promotions to developing countries, and the emerging nations of Central and Eastern Europe, unaccustomed to such high-pressure sales pitches.

In most developing countries, smoking by women and girls is limited by traditional social custom and mores, and lack of economic resources. As women in developing countries advance politically and economically, the tobacco industry hopes to link smoking to women's emancipation and independence, as was done in the United States. In Asia, the entry of an American company into a previously closed market increased smoking among women and girls. Ominously, in some urban areas of Latin America, highly educated young women smoke at a higher rate than their male counterparts.

Decreasing Women's and Girls' Tobacco Use

Working with Women's Organizations

Women's and girls' organizations are likely allies in the effort to decrease tobacco related illness among their constituents. There are an enormous number of women's organizations, including civic, business and professional, religious, sport and leisure organizations, sororities, and others. There are also organizations which serve girls specifically, and others which serve youth of both genders. The organizations are of varying scope—international, national, regional, state, or local—and of varying size. The

collective membership includes large numbers of women and girls; moreover, they are often very influential in their community.

With few exceptions, these organizations have not been leaders in tobacco control issues, principally because the health community has never sought their involvement in a concerted way. However, their potential for educating their members and their community is enormous.

Women's Political and Leadership Organizations

Women's political and leadership organizations are a small, but important subgroup of women's and girls organizations. These organization's participation in tobacco control has been limited because of funding constraints and competing priorities. Many women's organizations feel that tobacco issues are the purview of the voluntary and government health agencies, and that their main role is to provide information and services which are not available elsewhere. Many organizations have long been enmeshed in the struggle to secure and maintain reproductive freedom. As Bobbie Jacobson has said in *Beating the Lady Killers: Women and Smoking*,

"In the face of repeated threats to reproductive rights from the 'moral majority' it is easy to understand why the American women's movement sees smoking as a peripheral issue."

In part, however, the reticence of women's leadership and political organizations to participate in tobacco control activities stems from dependence on tobacco industry monies. The tobacco industry has targeted these organizations for financial support, precisely because their involvement in tobacco control activities would be devastating to the industry. For example, a Philip Morris internal document delineated the names of women's organizations, the amount of money given, and the kind of pay-back Philip Morris received; for example, public opposition to increased excise taxes.

Generally, neither the tobacco industry nor women's organizations which receive funding are eager to have these arrangements known to the public. A rare exception to this rule came in 1989, when a prominent women's political organization gave an award to George Knox, Vice President of Philip Morris Companies Inc. Although it may be difficult to assess the industry's influence, it is thought to be substantial.

Increasingly, however, tobacco industry support of women's organizations is recognized as ethically unacceptable, and as an embarrassing liability. *Hadassah* magazine stopped accepting tobacco advertising at the request of the organization's membership in 1987. Similarly, the National Organization for Women (NOW), stopped accepting tobacco industry contributions several years ago. Other women's organizations are considering adopting these positions. This is an important trend, which should be lauded and encouraged by the health community.

Women's Health Organizations

Several women's health organizations have had a long and active involvement in tobacco control. The American Medical Women's Association, the National Women's Health Network, the Boston Women's Health Book Collective, Girls Inc., and others, have worked to educate women on the health risks of tobacco, encouraged cessation, and, most important, opposed the tobacco industry's targeted marketing to women and girls. The efforts of these groups have been hampered by insufficient resources, competing priorities, and often, by poor ties to the mainstream of tobacco control.

Health Organizations

The major federal health agencies and the voluntary health organizations were asked to provide information about their agency's tobacco prevention and cessation programs specifically targeting women and girls (Appendix I). With few exceptions, programs have targeted pregnant women and mothers of young children. Although these programs are very important to improve and protect maternal and child health, they do not target the majority of women and girls. Critically lacking are prevention and cessation programs which target women and girls throughout their lives, and which address the social and economic causes of female tobacco use. Additionally, these agencies have rarely sought to involve women's and girls' organizations in their outreach efforts.

Recommendations

Tobacco control policies must be socially responsible and gender-sensitive, to reflect women's inequality and fewer resources in society. Ideally, these policies will be developed in conjunction with social, economic, environmental, and welfare policies.

Research Recommendations

- The federal and voluntary health agencies should support research on how tobacco affects women across the life cycle. To facilitate this, data should be collected and analyzed, and programs developed, by race, class, gender, and sexual orientation. The information obtained should be disseminated in both professional and lay publications. Specific research issues should include:

- smoking prevention, initiation, maintenance, cessation, and relapse specific to women.

- the use of nicotine replacement therapy during pregnancy.

- qualitative research which explores the impact of advertising and promotion of tobacco products on women.

- the extent to which women's groups accept tobacco money and how this effects their activities.

- how tobacco control laws, regulations, and policies differentially affect women.

- economic issues, such as the market share women represent, amount of money women spend on tobacco, and the effect of increased excise taxes on a family's nutritional status.

Action Recommendations

Women will benefit greatly from general measures aimed at preventing and decreasing tobacco consumption, including advertising restrictions, clean indoor air measures, increased excise taxes, and restrictions on youth access. However, specific steps are necessary to prevent and decrease tobacco consumption among women and girls.

1. The Office on Smoking and Health of the Centers for Disease Control and Prevention should work in collaboration with other appropriate agencies to coordinate an on-going, national, women-centered prevention and cessation program for women across the life cycle. The program should include research, policy, and public information components.
2. Tobacco control organizations should continue to strive to reflect the populations they serve, by including more women, and racial and ethnic minorities in positions of policy and program development and implementation.
3. Populations with a high prevalence of smoking are already disproportionately burdened by tobacco. Therefore, excise tax increases should be offset in part by the earmarking of funds for programs that specifically benefit these populations.
4. The Women's Health Initiative of the National Institutes of Health should include the prevention and reduction of tobacco use among women and girls.
5. Legislators at the federal, state, and local levels should receive briefings on women, girls, and tobacco issues.
6. Proposals for health care reform should include tobacco use prevention and reduction in women and girls.
7. The Congressional Caucus on Women's Issues should

   • request the Federal Trade Commission to assess both the impact of advertising and promotion targeting women, and the amount of tobacco industry expenditures devoted to promoting tobacco use among women and girls; and

   • request the Women, Infant, and Children (WIC) program to prohibit smoking in its clinics and request the clinics provide cessation and educational materials that are culturally and gender appropriate to program participants.

Suggested Reading

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Appendix 1

American Cancer Society (ACS)

The ACS has two programs targeting pregnant women. "Special Delivery", a smoking cessation program to assist low-income pregnant women to stop smoking, and "Don't Start Life Under a Cloud", a self-help guide targeting pregnant women.

American Heart Association (AHA)

None specifically targeted to women and girls.

American Lung Association (ALA)

"Freedom From Smoking for You and Your Baby" is ALA's 10-day quit smoking program for pregnant women. "I Quit Smoking Because I Love My Baby", available in English and Spanish, is an introductory packet describing why women should quit when they are pregnant and remain abstinent after delivery. "Smoking and Pregnancy" is a pamphlet describing about smoking during pregnancy. The ALA collaborated with the American Academy of Pediatrics to develop "Healthy Beginnings: The Smoke Free Family Guide for New Parents" to help health professionals educate new parents on environmental tobacco smoke. "Stop Smoking Stay Trim, ", which addresses concerns about gaining weight after quitting smoking, targets both pregnant and non-pregnant women.

Division of Cancer Prevention and Control (DCPC), National Cancer Institute

There have been numerous research studies on women and smoking funded by DCPC. However, the American Stop Smoking Intervention Study for Cancer Prevention (ASSIST) project, in which 17 states are funded to develop tobacco control programs, has no programs specifically targeting women or girls. Individual ASSIST states may be developing women-centered programs. DCPC has also produced a self-help guide for pregnant women and new mothers, "Don't Smoke There's a Baby in the House."

Office on Smoking and Health (OSH), Centers for Disease Control and Prevention

"Is Your Baby Smoking?", highlights the dangers of passive smoking to infants and children. "Pregnant? That's Two Good Reasons to Quit Smoking," discusses the dangers of smoking to the fetus. Both are available in English and Spanish. OSH also produces the Surgeon General's reports on the health consequences of smoking. The 1980 Report was entitled "The Health Consequences of Smoking for Women".

Children and Youth

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Children and youth hold the key to preventing tobacco use—the single most important preventable cause of death, disease, and disability in the United States. Although smoking and chewing tobacco adversely affects people of all ages, the addiction that leads to life-threatening illness largely begins during childhood and adolescence. Over 90 percent of adults who smoke cigarettes start smoking before age 20, and two-thirds of adult males who use smokeless tobacco (chewing tobacco and snuff) initiate use before they are 21 years old. Preventing tobacco use among the young therefore must be the highest priority in tobacco control policy.

Tobacco Use by Children and Youth

Over 4 million American teenagers regularly smoke, and half a million males between 12 and 17 years of age use smokeless tobacco at least weekly. Every day of the year, more than 3,000 additional young people in the U.S. try their first cigarette and an unknown number try snuff "dipping" and tobacco chewing. The younger individuals are when they start to use tobacco, the more likely they are to become heavy users in later years and to have difficulty in quitting. Unfortunately, by all methods of calculation, the average age of smoking initiation is dropping. Comparable data are not available for smokeless tobacco use, but tobacco chewing and snuff dipping has been observed among pre-school children.

The onset of smoking is viewed as a process evolving from preparation and anticipation to initiation, experimentation, and then maintenance of regular smoking. Less is known about the etiology of smokeless tobacco use, but the process of onset appears similar. Different determinants seem to be influential at each stage of onset, and individual children, as well as cohorts of youth, progress through these stages at a variable pace. These concepts imply that the challenges of prevention change with children's development, personal characteristics, and social environment.

Early Childhood. Through early learning from their environment, children develop attitudes about tobacco use and intentions to try it themselves. Prevention may be most effective at this stage; however, tobacco use by family members and tobacco industry practices undermine preventive efforts. Parents and older siblings who smoke or chew teach children that tobacco use is socially acceptable, model the specific behaviors involved in use, and increase youngsters' access to tobacco products. Some children report trying their first puff of a cigarette or taste of chewing tobacco at age five or six. In such cases, tobacco frequently is supplied by a family member.

Late Childhood and Early Adolescence. The proportion of children who have tried tobacco gradually increases through the upper elementary grades, and then jumps sharply with the transition to middle or junior high school. Substantial increases occur each year thereafter. Two recent surveys both found that among high school students who had ever smoked, about one-quarter had smoked their first cigarette by grade 6, one-half by grade 8, three-fourths by grade 9, and 94 percent by grade 11. Whites start smoking at a younger age than blacks, and males tend to begin smoking earlier than females, but girls catch up with higher rates of initiation in grades 7-9. Trial of smokeless tobacco varies markedly by gender, age, and geographic region. For example, the proportion of sixth grade boys who have tried smokeless products ranges from 7 percent in New York City to 68 percent in rural Montana. Youth who try smokeless tobacco also tend to experiment with cigarettes.

Children try tobacco for many different reasons; however, initiation is strongly associated with tobacco use by family members and friends. The great majority of youngsters first use tobacco socially with peers. Social influences also lead to repeated tobacco use; however, youngsters who have an initial aversive reaction, those who experience few symptoms or feel dizziness may be especially likely to try tobacco again. With continuing experimentation, social and physiological reinforcement is experienced and conditioned. By the eighth grade, 8 percent of both boys and girls report smoking a pack or more of cigarettes in the past month, and this proportion more than doubles by grade 10. Many light smokers make the transition to daily smoking by age 14.

Adolescents of High School Age. Smoking prevalence among adolescents has been estimated in several surveys with differing results. Differences in sampling and other aspects of survey methodology may account for differences in findings, but such variations make it difficult to estimate true smoking prevalence among youth of high school age. For example, the proportion of tenth graders who smoked in the past month was reported to be 21 percent and 30 percent, respectively, by the 1991 Monitoring the Future survey and the 1990 Youth Risk Behavior Survey (YRBS). The YRBS survey also found that 36 percent of all students in grades 9-12 had smoked in the past month, while the Teenage Attitudes and Practices Survey (TAPS) conducted one year earlier

found smoking prevalence among youth ages 12-18 to be 16 percent.

Monitoring the Future provides useful trend data through an annual survey of high school seniors. In 1991, this survey found that about two-thirds (66%) of graduating high school seniors reported ever smoking, 28 percent smoked in the past 30 days, 19 percent were daily smokers, and 11 percent smoked a half-pack or more per day. Reflecting the inverse relationship between smoking and educational level in the adult population, the prevalence of daily smoking among seniors who plan to attend college is about half that of seniors who are not college bound (14% v 30%). However, since this survey excludes school drop-outs, it underestimates smoking prevalence in the 17-19 year-old age group. Drop-outs smoke at a rate as high as 75 or 80 percent.

Smoking among high school seniors declined by approximately one-third from the mid-1970s to the early 1980s, but very little change has occurred subsequently. In 1991, smoking in the past month was down only 1 percent from 10 years earlier, while daily smoking was down less than 2 percent. From 1977 until recently, the rate of daily smoking among senior girls consistently exceeded that of senior boys by about 4 percentage points; however current data show seniors boys and girls smoking at about the same rate.

Due to increased use of smokeless tobacco, which has been heavily marketed to young men in recent years, more teenage male than female teenagers use tobacco products. Between 1970 and 1986, males aged 17-19 years of age increased their use of snuff fifteenfold and that of chewing tobacco more than fourfold to become the age group with the highest rate of smokeless tobacco use in the U.S. In 1985, over 8 percent of males aged 17-19 reported current use of smokeless tobacco. In the 1990 YRBS survey, use of smokeless tobacco within the past 30 days was reported by 19 percent of male respondents. Regular use of smokeless tobacco by girls is rare, except among American Indians.

In 1990, for the first time, smoking prevalence among black and white adults was similar (about 26%). However, many fewer black than white high school seniors report daily smoking (8% v 20%). The 1990 YRBS survey of youth in grades 9-12 also found smoking prevalence lower among blacks: 36 percent of whites and 31 percent of Hispanics, but only 16 percent of blacks reported smoking within the past 30 days. The TAPS survey of youth ages 12-18 yielded lower smoking rates, but the same rank order of smoking prevalence among ethnic groups: 18 percent of whites, 12 percent of Hispanics, but only 6 percent of blacks reported smoking in the past 30 days. Black and Asian adolescent males are less likely to use smokeless tobacco than are white and Hispanic males, while American Indian males and females report higher rates of use than youth in other ethnic groups. Nonetheless, ethnic patterns of smokeless tobacco use may vary by region.

Little is known about adolescent cessation of tobacco use, but several studies indicate that from 18 to 25 percent of youth who smoke stop within one year. Data from Germany suggest that teenagers may go through several cycles of experimentation, regular smoking, and cessation before becoming either confirmed smokers or quitters. In 1991, only 17 percent of graduating high school seniors who had ever smoked regularly reported that they did not smoke at all in the past 30 days.

Older Adolescents and Young Adults. The transition to adulthood is symbolically marked by the 18th birthday at which age young people in most States can legally purchase tobacco for the first time. Other changes in work, school, and living arrangements alter social status and roles, initiating processes of self-redefinition. Tobacco use may be initiated or intensified during this vulnerable period.

Data collected from ever smokers aged 20-24 indicate that about 33 percent of these males and 37 percent of these females start smoking between ages 18-20. Sharp increases in the initiation of cigarette smoking through the late teenage years also have been observed in a longitudinal study. Follow-ups to the annual survey of high school seniors have found more modest increases in smoking initiation after high school, but respondents who were active smokers while in high school reported smoking more intensively after graduation.

Smoking rates among college students vary with the type of institution attended. In a 1989 survey of full-time college freshmen, "frequent smoking" within the past year was reported by 12 percent of men in two-year colleges, 7 percent of those enrolled in four year institutions, and slightly under 6 percent of those attending universities. Comparable figures for freshmen women were 17 percent, 9 percent, and 8 percent, respectively. After a 22 year decline in the proportion of college freshmen who reported frequent smoking, rates rose in 1988. In this same year, a record high percentage of freshmen said they frequently felt depressed, while a declining proportion rated their emotional health above average. These data are consistent with research associating tobacco use with stress.

In 1990, smoking prevalence among young adults ages 20-24 was 29 percent for males and 24 percent for females. However, smoking prevalence was 55 percent for males and 47 percent for females who had less than 12 years of education, compared to 16 percent of males and 14 percent of females who had attended college. Whites smoked at a higher rate than blacks (39% v 24% for males, 28% v 17% for females). Hispanic males smoked at about the same rate as white males, but smoking was reported by only 15% of young Hispanic women. There are no reliable estimates of smoking prevalence among young adults in other ethnic groups. Several studies show that a large proportion of young adults who smoke have made one or more attempts to quit, but smoking cessation in this age group is limited. In 1987, regular smokeless tobacco use was reported by 9 percent of males aged 18-25.

Adolescent Smoking during Pregnancy. Smoking prevalence among pregnant women in the United States is estimated at 25 percent or greater; however, smoking prevalence among pregnant teenagers is unknown. A comparison of data collected from married women in 1967 and 1980 revealed a decline in smoking

rates during pregnancy for some groups, but rates among married teenagers remained fairly constant at 39 percent for whites and 27 percent for blacks. No data were available on smoking prevalence among unmarried pregnant adolescents, but rates were projected to be higher.

Health Consequences of Tobacco Use

Addiction. Tobacco use is the most widespread form of drug dependence in the United States. The processes that determine addiction to tobacco are similar to those that determine addiction to other psychoactive substances such as heroin and cocaine. Nicotine addiction can quickly become established in children, as evidenced by the difficulty that youth who smoke and chew tobacco often have in quitting.

Cigarette Smoking. Tobacco smoke contains over 4,000 known compounds, including many that are pharmacologically active, toxic, mutagenic, or carcinogenic. The fact that the constituents of cigarette smoke have diverse biological effects helps to explain why smoking has multiple adverse health consequences. Although the tobacco industry has developed filtered, low-tar, and other cigarette forms purported to reduce the health hazards of smoking, no cigarette or level of smoking can be considered safe. The start of even modest cigarette smoking during the school-age years reduces lung function, increases respiratory symptoms, and results in pathologic changes. Conversely, smoking cessation has major and immediate health benefits for persons of all ages and for those with and without smoking-related disease.

One-fourth or more of all regular smokers die of smoking-related diseases. Thus of the 3,000 young people who start smoking every day, approximately 23 will be murdered, 30 will die in traffic accidents, and 750 will die from smoking-related disease. If adult smoking rates remain at the current level of about 26 percent, 18 million of the 70 million children now living in the United States will smoke cigarettes as adults and nearly 5 million of them will die as a consequence. As former Surgeon General Koop observed, "This figure should alarm anyone who is concerned with the future health of today's children".

More than one of every six US deaths, or an estimated 434,000 deaths annually are directly attributable to cigarette smoking. Smoking causes more premature deaths than caused by AIDS, cocaine, heroin, alcohol, fire, automobile accidents, homicide, and suicide combined. The cigarette toll includes an estimated 87 percent of lung cancer deaths, 30 percent of all cancer deaths, 21 percent of deaths from coronary heart disease, 18 percent of deaths from stroke, and 82 percent of deaths from chronic obstructive pulmonary disease. Smoking also causes over 145 million days of excess bed disability and over 80 million excess days of work lost each year. The annual cost of smoking-related health care and lost productivity in the United States has been estimated at about $65 billion, or $2.17 for every pack of cigarettes sold. The more than 1 million young persons who start to smoke each year will add an estimated $10 billion to the cost of health care in the US during their lifetimes.

Maternal smoking during pregnancy. Maternal smoking during pregnancy retards fetal growth and is associated with an increased incidence of spontaneous abortion, stillbirth, premature delivery, low birth weight, sudden infant death syndrome, and infant mortality. In the United States, cigarette smoking during pregnancy accounts for 20 to 30 percent of low birth weight babies, up to 14 percent of preterm deliveries, and about 10 percent of all infant deaths. The risk of these outcomes increases with the number of cigarettes smoked by pregnant women. Smoking cessation prior to or early in pregnancy can partly reverse the reduction in infant birth weight associated with maternal smoking.

Smokeless Tobacco. Snuff "dipping" and tobacco chewing increase risk for cancers of the oral cavity. Short term effects include gingival recession and oral leukoplakias (precancerous white patches), as well as sores, blisters, and ulcers on the gums, lips, and tongue. Other effects on both soft and hard tissues of the mouth are suspected, but have not been confirmed. Swallowing the excess saliva produced by smokeless tobacco use can produce nausea and other symptoms. Because smokeless tobacco use can lead to nicotine dependence, scientists also are concerned that its use may result in increased cigarette smoking.

Tobacco Use and Other High Risk Behavior

Tobacco use by youth is widely recognized as the "gateway" to other high risk behaviors. Both cigarette smoking and smokeless tobacco use are highly correlated with use of alcohol, marijuana, and other drugs. Although young people often experiment with alcohol before they try tobacco, tobacco use is more likely to lead to dependence. Moreover, increasing levels of tobacco use are associated with increased use of other psychoactive substances, and development of tobacco dependence appears to precede development of dependence on alcohol and illicit drugs.

Adolescent females who smoke and drink are more likely to become sexually active at an earlier age and to be less effective users of contraception than girls who abstain from tobacco and alcohol use. Tobacco use by youth is also linked with low school achievement, rule-breaking, and general delinquency. Smoking and chewing in combination with other behaviors often multiplies the risk of health, as well as social problems. For example, use of tobacco with alcohol substantially increases the risk of developing oral and pharyngeal cancers. Girls who smoke and use oral contraceptives greatly increase their risk of cardiovascular disease.

Children's Exposure to Environmental Tobacco Smoke

Exposure to environmental tobacco smoke (ETS) is a cause of disease, including lung cancer and various respiratory illnesses, in healthy non-smokers. Currently 53,000 U.S. deaths annually are attributed to ETS; 3,000 of these are due to lung cancer. Estimates indicate that more nonsmokers will die as a result of exposure to ETS than from exposure to any other air pollutant. Those most affected by ETS are children.

Infants who are nursed by smoking mothers and who are exposed to ETS in their home absorb tobacco constituents, even when smoke is blown away from the baby, room ventilation is increased, or smoking occurs in another room. A recent study found that infants are three times more likely to die from sudden infant death syndrome (SIDS) if their mothers smoke during and after pregnancy, and are twice as likely to die if their mothers stop smoking during pregnancy but then resume following birth.

Children of parents who smoke are more likely than the children of non-smokers to develop bronchitis, pneumonia, and other lower respiratory tract infections. Each year second hand smoke causes lower respiratory tract infections in as many as 300,000 children under 18 months of age: up to 15,000 of these cases require hospitalization. Parental smoking is also causally associated with children's symptoms of respiratory irritation, including chronic coughing, wheezing, and phlegm production; with increased middle ear effusion, a sign of middle ear disease and the most common reason for hospitalizing young children for an operation; and with a reduction in children's lung function as tested by objective measures of lung capacity. In addition, exposure to ETS increases the number of asthma attacks and the severity of asthmatic symptoms in about 20 percent of the nation's two million to five million asthmatic children. Mothers who smoke 10 or more cigarettes a day can actually cause as many as 26,000 new cases of asthma among their children each year.

Since many children whose parents smoke become smokers themselves, the long-term effects of exposure to ETS during childhood have been difficult to study. However, a recent investigation found that approximately 17 percent of lung cancers among adult nonsmokers can be attributed to high levels of exposure to ETS during childhood and adolescence. Parental smoking also may contribute to the rise of chronic airflow obstruction in later life.

A 1986 survey found a cigarette smoker living in 39 percent of households with one or more children aged six or younger. Current estimates are that 9 to 12 million American children under five years of age, or one-half to two-thirds of all children in this age group, may be exposed to ETS in the home.

Tobacco Industry Activities

For the tobacco industry, youth who smoke and chew replace the 1,200 older Americans who die daily from tobacco-related disease and the 500 Americans per day who quit smoking and chewing tobacco. The industry's highly sophisticated marketing strategies provide pervasive encouragement of tobacco use. Concurrently, other industry activities impede efforts to limit the exposure of youth to marketing influence.

Product Development. The development of new products and packaging is an important component of marketing for the tobacco industry. The marketing of moist snuff provides a dramatic illustration. Prior to 1975, smokeless tobacco use rates were highest among persons over age 50. However, in the early 1970's, the industry extended its line of moist snuff products and began aggressively marketing them to males between ages 18 and 30, with a "substantial emphasis on the 18 to 24 group". Many young boys also were influenced. In 1973, US Tobacco introduced moist snuff in new packaging and carrying this round tin can in the back jeans pocket quickly became a status symbol among boys and young men. US Tobacco more than doubled its sales in the ensuing decade, and in 1983 the introduction of moist snuff in small premeasured pouches boosted sales still higher. These pouches contain a mild form of snuff and come with step-by-step instructions for use. Other products, varying in tobacco strength and flavor, provide a graduated continuum to addiction.

Advertising and Promotion. Youth are bombarded with appeals by the tobacco industry. In 1990, the tobacco industry spent $3.99 billion to advertise and promote its products, a 10% increase from the previous year and over twice the amount spent ten years earlier. The current figures translate into about $10.9 million each day or over $7,650 each minute spent on tobacco advertising and promotion. Promotional expenditures are growing while advertising expenditures are shrinking. Whereas advertising represented 87% of total spending in 1970, it now represents less than 30%. Promotion includes such activities as offering free trials (e.g., samples) or discounted purchase of a product (e.g., coupons), the appearance of a tobacco product name on television (e.g., sports sponsorship), and sponsorship of cultural and community events.

Although the tobacco industry vociferously denies that its advertising is directed to young people, awareness of cigarette brands has been demonstrated in children. For example, a recent study found that preschool children recognize "Old Joe Camel" as well as Mickey Mouse. Other research shows that brand preference is much more tightly concentrated among adolescent smokers than among adult smokers, and that teenagers who purchase their own cigarettes prefer those brands most heavily advertised.

In 1981 the Federal Trade Commission forced cigarette manufacturers to release a study revealing a five point strategy for reaching youth. This information was excluded from the public version of the FTC report, but leaked to the public. The recommended techniques are still apparent in tobacco advertising: tobacco use is associated with maturity, good times, good looks, popularity, independence, affluence, adventure and risk-taking. These themes relate to basic developmental needs of children and adolescents. In essence, they promote tobacco use as a sign of adulthood and a short-cut to the difficult processes of growing up.

The tobacco industry maintains that advertising and promotion is directed to influencing brand preferences among current tobacco users. This brand switching argument flies in the face of logic because only about 10 percent of tobacco users switch brands each year and much brand switching occurs among brands owned by the same company.

Aside from recruiting replacement smokers and decreasing the resolve of current users to quit, the high saturation of tobacco advertising and promotion helps to create an environment in which tobacco use is considered socially acceptable, if not desirable. In addition, studies have found an inverse relationship between cigarette advertising revenue and coverage of tobacco

and health issues in national women's magazines, illustrating that tobacco advertising serves to silence editorials and coverage of tobacco control issues in magazines that accept tobacco advertisements.

Recently several major print advertisers whose products have nothing to do with tobacco have featured cigarette smoking models. Guess jeans ran an advertisement in the October 1992 issue of *Esquire* showing their newest model, Anna Smith, in a sexy pose holding a cigarette with a dangling ash. Cigars are focal points in new print ads for Bijan Fragrances and Donna Karan fashions. Cigarette smoking is also showing up in photographs that appear with magazine stories. A recent issue of *Vanity Fair* ran several photos featuring Luke Perry of the "Beverly Hills 90210" television series smoking with gusto. In one picture, a pack of Marlboro cigarettes was sticking out of his front pocket. Advertising psychologists say that the sexy and rebellious images of these smoking models, similar to those promoting tobacco products, could strongly influence teenagers.

Product Placement. Tobacco is widely available in supermarkets, drugstores, convenience stores, gas stations, and vending machines. This pervasive availability not only encourages impulse buying and makes tobacco easily accessible to youth: it conveys messages that tobacco products are safe, in great demand, and an integral part of everyday life. Product placement within stores often reinforces these impressions. For example, one survey of stores surrounding California high schools found smokeless tobacco next to candy and snacks in 42% of these establishments. Conversely, placing tobacco products next to alcohol or out of consumer reach behind the counter associates use with the attainment of adult status, or for youth, with risk-taking.

Sales Force. The tobacco industry has an extraordinary sales system with over 1.4 million outlets. Incentives are offered to salespeople at every level from clerks who are encouraged to wear clothing with tobacco product logos to wholesalers who can strive to be named Masters in Distribution Excellence. Field representatives assure that products are fresh and optimally placed to encourage sales. They serve as emissaries for their products by providing retailers and customers with friendly, personalized attention. At the same time, they obtain ideas for further market development. This sales system also has the potential for political action. In Fall 1992, field representatives in New Jersey brought copies of articles about proposed tobacco tax hikes to each of their retail stores. Retailers can earn Masters points by writing letters to newspapers and politicians.

Philanthropy. The enormous profits derived from tobacco sales allow companies to generously fund a variety of community service, cultural, sports, and artistic groups, some of whom are connected to youth. The tobacco companies have prominently supported the events of these organizations, making their contributions well known in the community and often earmarking funds for high profile items such as directories, annual meetings, internships, and cultural events. Not surprisingly, these organizations rarely support tobacco control measures and often defend the "rights" of tobacco companies.

Public Relations. The tobacco industry engages public relations firms and works through the Tobacco Institute to help create a positive image for tobacco companies and a less negative image for their products. For example, Philip Morris sponsored a high tech multi-million dollar national tour of the Bill of Rights on its two-hundredth anniversary as a means of championing the company's commitment to freedom and free speech. The tour offered the company entre to school children, for whom they developed a Bill of Rights curriculum, as well as occasion subtly to frame tobacco use as a civil right.

The industry's public relations efforts include a long history of disinformation. At every opportunity, industry spokespersons refute the dangers of active tobacco use and passive smoking, reframe the discussion from health to smokers' rights, and emphasize how they oppose minors using tobacco.

Smoker's Rights. In efforts to promote the idea of tobacco use as a right, the tobacco companies have supported "grassroots" smokers' rights organizations, providing them with materials and promotional support. Their publications encourage smokers to contact their elected representatives about tobacco issues, often providing ready-to-send postcards.

Political Campaigns and Lobbying. The tobacco companies are consistently among the top non-partisan campaign contributors at national and state levels and provide numerous perquisites for elected officials (e.g., "conferences" held at resorts). Well-paid lobbyists for the industry are ubiquitous, working to prevent the introduction of tobacco control legislation, to pass weak legislation that undermines tobacco control goals (e.g., weak state laws that preempt stronger local ordinances), and to challenge existing laws through ballot measures. To create the perception of broad support, the industry covertly funds front organizations to serve as its representatives. Tobacco industry insiders are often active at the highest levels of government. As a recent example, President Clinton's transition team was led by Vernon Jordon, Head of the Urban League and a Board Member of RJR Nabisco. Mickey Kantor, a Los Angeles attorney who often represents Philip Morris, was also on the team, and is now the US Trade Representative.

Illustrations of Tobacco Industry Strategies. The tobacco industry has developed various campaigns to create positive public perceptions and to influence policy decisions. In December 1990 the Tobacco Institute launched "It's the Law", a highly publicized campaign to "discourage" sales of tobacco to minors. The Tobacco Institute stated that it would spend $10 million over five years on this campaign. In comparison, current estimates are that illegal sales to minors will generate over $1 billion in profits for the tobacco companies over this same period.

Point-of-purchase signs are the primary component of the campaign. These read "It's the Law / You must be 18 to buy tobacco products", but one study has shown these signs to be ineffective. Interestingly, the sign's message is inaccurate in those states where it is illegal for retailers to sell tobacco to minors and not for them to buy it. The subtle shift in responsibility away from the retailers to minors and their parents is a common strategy used

by the tobacco industry. The campaign also has a legislative strategy to pass weak statewide laws that preempt any stronger action at the local level where communities have been successful in passing strong, pro-health legislation. Finally, the campaign includes distribution and advertisement of a booklet entitled "Tobacco: Helping Youth Say No." The booklet, distributed to governors, school boards, community groups, and parents who request it, frames smoking as an adult decision and makes no reference to the health and addictive effects of tobacco use.

"Support the Law—It Works" is a similar campaign started in 1992 by RJR Nabisco. Like "It's the Law", the program centers around the posting of signs and educating merchants through a videotape about sales to minors.

National Health Objectives

National health objectives for the year 2000 set challenging targets for tobacco use prevention and control. These include reducing smoking initiation among youth and smoking prevalence among adults to no more than 15 percent, reducing smokeless tobacco use to a prevalence of no more than 4 percent among men ages 12 through 24, reducing to no more than 20 percent the proportion of children age 6 and younger who are exposed to cigarette smoke at home, increasing to 50 percent the proportion of smokers age 18 and older who make serious quit attempts each year, and increasing smoking cessation among pregnant women to 60 percent.

Related service and protection objectives particularly relevant to children and youth call for establishing tobacco-free school environments; including tobacco use prevention in the curricula of all elementary, middle, and secondary schools, preferably as part of quality school health education; enacting in 50 States comprehensive laws on clean indoor air that prohibit or strictly limit smoking in enclosed public places; enacting and enforcing in 50 States laws prohibiting the sale and distribution of tobacco products to youth younger than age 19; increasing to 50 the number of States with plans to reduce tobacco use, especially among youth; and eliminating or severely restricting all forms of tobacco product advertising and promotion to which youth younger than age 18 are likely to be exposed.

Establishing Tobacco-free Environments

A tobacco-free school environment is important not only to protect children and youth during the time they spend at school, but also to reinforce anti-tobacco messages in the classroom and the community. The 1991-92 National School Boards Association Survey sponsored by the American Cancer Society, the American Heart Association, and the American Lung Association found that 94 percent of school districts have a written policy with some restrictions on smoking, but only 40 percent of school districts have written policies that provide for a total ban of smoking on school grounds. Only 4 percent of districts allow smoking by students in designated areas in buildings, but 43 percent permit smoking by faculty, staff, and administrators in such places. General compliance with non-smoking policies and regulations varies, but most districts report that it ranges from good to excellent. Compliance is better in those districts with a total smoking ban.

Federal, state, and local legislation that prohibits smoking in other public places can do much to protect youth from passive smoke exposure. However, because these policies only protect youth in public settings, passive smoke exposure can be significant if parents or other family members smoke in enclosed places (e.g., at home or in the car).

Educational interventions encouraging voluntary action are the only feasible way to prevent passive smoking exposure in non-public settings. Research is needed to develop and test educational approaches that effectively lead parents and other adults to reduce the exposure of children and youth to passive smoking. Educational research is also needed to develop ways of helping children themselves develop skills in avoiding exposure to smoke from other people's cigarettes.

Educating Children and Youth about Tobacco

School-based Prevention Programs. In a 1988 survey of school districts, 78 percent reported providing antismoking education at the high school level, 81 percent at the middle school level, and 75 percent at the elementary school level. However, the nature and effectiveness of the antismoking education provided is unknown.

By the mid 1970s, research clearly established that merely providing information about the health hazards of tobacco use will neither prevent smoking onset nor motivate cessation among youth of any age. During the next decade, new theoretically-based, research-driven prevention curricula therefore were developed to help children understand and resist social influences promoting tobacco use.

Since smoking onset increases at the time that children make the transition from elementary school to a middle or junior high school, most of these programs are targeted to students in grades 6-9. In addition to teaching about ways in which parents, peers, and the media influence youthful smoking behavior, these programs emphasize the short-term physical and social consequences of tobacco use, social norms discouraging use, and the development of skills to resist pressures promoting use. They rely on experiential learning more than didactic teaching, and therefore require adequate teacher training. Many programs involve peers as teaching assistants. Controlled field trials conducted by the National Cancer Institute (NCI) and other agencies have shown that these programs have a positive effect in delaying the onset of tobacco use for up to three years.

Efforts are being made to disseminate these tested anti-tobacco curricula to schools and to encourage their utilization. A minimum of two 5-session blocks of classes on tobacco prevention, delivered in separate school years between 6th and 9th grade, is recommended. Tobacco use prevention can be included in the curriculum as a stand-alone program, as part of a substance use program, or as part of a school health curriculum. Nevertheless, tested tobacco prevention programs are not widely used in the

nation's schools. Where such a program has been adopted, teachers often modify the curriculum or teach only parts of it. Moreover, teaching about tobacco frequently changes from year to year. Overall, then, school-based education about tobacco tends to be sporadic and inconsistent.

While there is growing agreement in all sectors that tobacco prevention ideally should be part of a comprehensive K-12 school health curriculum, tested anti-tobacco programs are not readily available for elementary and high school students. Moreover, relatively few schools have a comprehensive health education program as a mandated part of the curriculum. As of 1989, school health education programs were mandated in 25 States and recommended by another 9 States, but the number of school districts actually implementing planned, sequential multi-topic school health programs has not been accurately estimated.

Reflecting the influence of Federal initiatives to prevent drug and alcohol use, many schools provide some instruction about these substances, but tobacco often receives minimal attention. For example, some schools have adopted a generic model of prevention which attempts to reduce risk factors and increase protective factors related to all forms of substance, as well as other health and safety problems of youth. Widely varied activities aimed at improving school achievement and self-esteem are classified as prevention, but these activities may not address tobacco use directly or even involve classroom instruction. There is no evidence that this generic model prevents and reduces tobacco use by youth.

Community-based Prevention Activities. The NCI-funded field trials of programs to prevent and control tobacco use included several projects that coordinated school-based approaches with interventions through the media and/or community-based activities. In addition, two programs were developed for and tested in community-based youth organizations, 4-H and Little League, respectively. These programs can enhance and complement school-based prevention programs, especially when they are well coordinated. The challenges of coordination, however, should not be underestimated.

Local communities with strong anti-tobacco coalitions have developed a variety of activities for children and youth. These range from traveling puppet shows and clowns encouraging tobacco-free environments to special youth forums on tobacco. While such activities help to communicate strong community norms against tobacco use, their effects on youthful behavior have not been evaluated. Some observers note that many of these activities are only one-time events that involve limited numbers of youth, most of whom are not at high risk for tobacco use.

Youth Smoking Cessation Programs. Few tobacco use cessation programs have been designed especially for youth, and of these, very few have proven effective. These latter programs tend to combine several individual or group counseling sessions with media, take-home materials, and telephone follow-ups. Resource requirements have inhibited widespread dissemination. Few schools or other organizations serving youth offer on-site cessation programs, and frequently staff members do not know how to refer youngsters who use tobacco to cessation programs in the community. The effectiveness of adult cessation programs for youth has not been evaluated.

Parent Education. Some tobacco use prevention programs have attempted to involve parents by informing them about the program, encouraging family television viewing of anti-tobacco interventions, and assigning homework that requires parent participation. Materials also have been developed to help parents and other care-givers instill strong anti-tobacco attitudes in children while they are very young. Although some parents are receptive, participation, at best, is uneven. Parents who use tobacco have been most difficult to reach.

Limiting Youth Access to Tobacco

Sales of tobacco generate huge profits for the tobacco industry, some of which are from illegal sales to minors. Such illegal sales—about 947 million packs of cigarettes and 26 million containers of chewing tobacco in 1988—total $1.45 billion in sales and generate more than $221 million of industry profits (3 percent of total profits). Retailers also profit an undetermined amount from these sales. Study after study has illustrated that minors have little trouble obtaining tobacco from generally any location where they attempt to buy it. Access is not concentrated in certain types or stores, or in certain parts of the country, or at particular times of the day. Overall, minors trying to buy tobacco are typically successful in purchasing it over-the-counter 50-75 percent of the time and from vending machines 80-100 percent of the time.

If parents, government officials, and health professionals are to succeed in convincing children and teenagers not to use tobacco, it cannot be sold as if it were milk or candy.

Although most states (n=46) and the District of Columbia have laws regulating tobacco sales to minors, they are rarely enforced. A review of those states with laws found that five had nominal restrictions (e.g., laws banning sales below a minimum age), 38 had basic restrictions (e.g., laws banning sales to teenagers under age 18, fines for the sales or distribution of tobacco to minors), four had moderate restrictions (e.g., the basic restrictions plus warning signs at point of purchase, state issued retail tobacco license, and a provision for license suspension or revocation when sales to minors are made), and no state had comprehensive regulations (e.g., moderate regulations plus a ban on free distribution of tobacco and coupons, use of license fees for enforcement, vending machine restriction or ban, absence of a preemptive clause, and allowance for compliance checks/stings at the local level).

A 1989 random digit dial population survey of 3,654 persons aged 25-64 in the 10 Community Intervention Trial for Smoking Cessation (COMMIT) cities illustrates the public strongly supports regulating minors' access to tobacco. Across the ten COMMIT cities, the percent of respondents agreeing to various policy states was as follows: tobacco products should be as strictly controlled as alcohol products (70 percent); merchants who sell tobacco to

minors should be fined (88 percent); and cigarette vending machines should be eliminated in places where teens gather (84 percent).

Most people now agree that merchant education is a necessary but not sufficient intervention to reduce over-the-counter tobacco sales to minors. Accessibility to cigarette vending machines is best prevented through eliminating these machines entirely. A less desirable but acceptable solution is to limit machines to bars.

Interventions that include active enforcement of access laws (eg, "stings" that result in citations of violators) and restrictions limiting access and availability (eg, bans on vending machines, restrictions on how over-the-counter sales are made) are needed for sustained reductions in minors' access to tobacco. These types of interventions require that public health professionals work in the political arena, an area in which many lack experience or expertise.

Administration of a tobacco vendor's license is another effective method for monitoring tobacco sales activity and for funding increased enforcement of laws. Consensus is that citations for illegal sales are most appropriately handled through civil rather than criminal courts. There has been considerable debate about the efficacy and desirability of laws that prohibit possession of tobacco by minors. Prime concerns are that making the possession of tobacco illegal may increase underground sales activity, enhance the attractiveness of tobacco use to youth who rebel against authority, and defect attention away from the retailers who illegally sell tobacco to minors and from the industry that promotes tobacco use to youth.

Interventions to Reduce the Advertising and Promotion of Tobacco

Warning Labels. The first of a series of Congressional statutes requiring warning labels on tobacco products and advertisements became effective in 1966. Congressional legislation passed in 1984 and 1986 now requires rotating health warning labels on all cigarette and smokeless tobacco packages and advertisements in the US. The effectiveness of these warnings has been difficult to establish, but research indicates that they their design neither draws attention nor encourages reading. One study of 61 adolescents found that 20 percent looked at warnings in magazine ads but did not read them, while 40 percent did not look at the warnings at all.

Efforts have been unsuccessful over a period of two decades to require disclosure of tobacco product and tobacco smoke constituents on packages and in advertising. Some cigarette manufacturers voluntarily disclose levels of selected constituents, such as tar and nicotine. Limited evidence suggests that information about the hazardous substances in tobacco may influence some adults to change brands, but the effects of such knowledge on children and youth are unknown. Because there is no known safe level of tobacco product consumption, disclosure of the constituents in tobacco is valuable only to the extent that this contributes to the prevention and cessation of product use.

Restrictions on Advertising. In response to anti-smoking public service announcements aired under the Fairness Doctrine between 1968 and 1970, the tobacco industry supported legislation banning cigarette advertising on television and radio, effective in 1971. In 1973 and 1986, this ban was extended to the broadcast advertising of little cigars and smokeless tobacco products, respectively. Nevertheless, tobacco billboards prominently displayed near scoreboards in sports arenas and industry sponsorship of sporting events assure that tobacco logos are frequently aired on television. These images associate tobacco with athletic prowess, health, and excitement. Televised sporting events draw large youth audiences.

The Federal Trade Commission has attempted to regulate false and misleading advertisements about tobacco, but despite some limited success, the regulatory process has been slow. Effects of these efforts on tobacco use behavior have been difficult to determine. Many proposals have been advanced to increase restrictions on the advertising and promotion of tobacco. Some would place tighter controls on the imagery and content of advertising either by developing and enforcing a stricter code or by permitting only "tombstone" advertising with no models, slogans, scenes, or colors. Other policy proposals would eliminate tobacco advertising and promotion as a tax deduction, prohibit advertising in certain media, prohibit certain promotional techniques, ban advertising and promotion accessible to children, or ban advertising and promotion of tobacco products completely. In 1988, Canada enacted a total ban which is now becoming effective in stages.

The Public Health Cigarette Smoking Act of 1969 (PL 91-222) preempts regulation of cigarette advertising by States and "any political division thereof", but the Comprehensive Smokeless Tobacco Health Education Act of 1986 (PL 99-252) does not preempt State and local regulation of smokeless tobacco advertising. Several states and local jurisdictions have banned tobacco advertising on public transit systems and the distribution of free cigarette samples. These local policies have not been challenged in court, but again their effects on tobacco use are unknown. At the very least, they may communicate the important message that tobacco use is not socially acceptable.

Counter-advertising. Because the anti-tobacco public service announcements broadcast in 1967–1970 apparently helped to neutralize tobacco advertising, the establishment of a continuous Government anti-tobacco campaign has been proposed. Taxing some portion of cigarette companies' advertising and promotion budget or earmarking a portion of the Federal cigarette excise tax have been identified as possible sources of funding to support such a campaign. Although these proposals have not progressed in Congress, several States have implemented aggressive tobacco counter-advertising media campaigns supported by increased State taxation on tobacco.

Certain activist organizations have been highly creative in counter-advertising against tobacco. For example, members of Doctors Ought to Care (DOC), dressed in white coats, make "house calls" at local events sponsored by the tobacco industry. Stop Teenage

Addiction to Tobacco (STAT) emphasizes community organization to protest the sponsorship of local events and the free distribution of samples by tobacco companies. DOC, STAT, and other groups also produce humorous and hard-hitting posters and promotional items spoofing tobacco advertising themes. Increasingly, schools and community groups are involving youth in the creation, production, and dissemination of local counter-advertising materials.

Economic Interventions

Options for exerting economic pressure on the tobacco industry include taxes, divestment, shareholder resolutions, boycotts, and litigation. Each of these strategies is briefly reviewed below.

Taxes. Because children and adolescents typically have less disposable income than adults, their decision to purchase tobacco products is affected by its cost. There are several components to the cost of tobacco—manufacturers' price, wholesale and retail markups, tobacco taxes, and sales taxes. While the tobacco industry routinely increases its prices, increasing state and federal excise taxes is a potent and available means for increasing cost. The price elasticity of demand for cigarettes ranges from -0.2 to -1.4. A -0.2 elasticity means that a 10% increase in the price of cigarettes results in a 2 percent decrease in consumption. A -1.4 elasticity means that a 10 percent price increase results in decreases consumption by 14 percent. The few studies of tobacco price elasticity among youth have found it to be at the higher end of this range. Teen smoking in Canada has been cut by about two-thirds since 1980 when taxes on tobacco began rising.

Unwanted Profits. Representatives of the tobacco industry have stated that they do not want to sell their products to children and that profits on sales to minors are unwanted. Accordingly, it has been proposed that tobacco companies should donate these unwanted profits to state health departments for prevention. In 1989, this donation would have amounted to an estimated $270 million.

Divestment. In recent years, divestment of tobacco stocks has become a new strategy in the tobacco control effort. Universities such as CUNY, Harvard, Johns Hopkins, and Tufts have all divested. Other organizations, including the Robert Wood Johnson Foundation, the Henry J. Kaiser Family Foundation, and the American Medical Association also have divested.

Shareholder Resolutions. Filing of shareholder resolutions is a relatively new strategy employed by tobacco control activists. Resolutions have been filed both with tobacco companies and companies associated in some way with tobacco (eg, media, companies that make elements of tobacco products, pharmacies, insurance companies, etc). For example, at the 1992 annual meeting of Philip Morris, a resolution was presented asking the Board to evaluate its efforts to dissuade youth from using tobacco. The Board rejected this resolution, but it was supported by about 7 percent of the shareholders.

Boycotts. Boycotts of consumer products have proven to be an effective practice in influencing corporate behavior. Stop Teenage Addiction to Tobacco (STAT) has an ongoing campaign to boycott Nabisco food products. Although the effects of this boycott on RJR Nabisco are not readily apparent, it does serve to raise public awareness of corporate behavior and gives individuals a relatively simple, concrete way to express their feelings about RJR.

Litigation. Litigations targeting unfair and illegal consumer practices directed at youth has begun to appear in recent years. A landmark case in Massachusetts (*Kyte v Store 24 Inc*) was brought by two smoking teenagers who were illegally sold cigarettes by Store 24. This case was settled when the Store 24 convenience store chain agreed to require proof of age from younger looking customers attempting to buy tobacco.

Federal Leadership to Prevent and Reduce Tobacco Use

Despite strong public support for tobacco control measures, Congress has taken relatively few votes on tobacco control legislation in the past 30 years and has yet to take any significant action to combat this public health problem. The United States lags far behind other industrialized countries in federal tobacco control policies.

The 1989 Surgeon General's Report, *Reducing the Health Consequences of Smoking: 25 Years of Progress*, states that "Government smoking control efforts have been characterized by some observers as modest." In that year, the Office on Smoking and Health (OSH), the only Federal agency devoted exclusively to the smoking issue, had a budget that, in real dollars, was roughly one-half of the budget in 1966 when its predecessor, the National Clearinghouse, was established. Recently relocated to Atlanta, the OSH continues to provide important leadership in the prevention and control of tobacco use. The budget of the Office has been tripled and staff expertise has been enhanced. The Office is now positioned to have a substantial influence on tobacco prevention and control. With continued financial support comprehensive prevention programs can be widely supported.

From 1983 through 1990, the Smoking, Tobacco, and Cancer Program in the Division of Cancer Prevention and Control within the National Cancer Institute (NCI) provided a strong federal focal point for research on effective community-based strategies to prevent and reduce tobacco use in high risk populations, including youth. However, leadership for this program has been weakened in recent years by decentralizing program components and moving them out of the office of the Division's Director to various Branches. The NCI's 1994 ByPass budget narrative acknowledges that the prevention and control of tobacco-related cancers represents one of the areas most ready for wide-spread dissemination of research results and also describes plans for new research on the development and testing of smoking cessation programs for adolescents, as well as for older Americans. However, research on tobacco control no longer stands out as one of the NCI's top priorities. The Bush administration proposed cuts for cancer prevention and control in the NCI's 1993 FY budget. Although funding was restored by Congress, reports of appropriations committees neither mentioned smoking nor identified lung cancer as a priority for prevention.

Recommendations

The tobacco industry historically has responded to tobacco prevention and control efforts with creative, highly sophisticated, sensitively targeted, and well-financed counter-measures. Intensified efforts, multiple strategies, and a coordinated plan of action therefore will be required to prevent and reduce tobacco use among youth and to achieve related National Health Objectives. (Priority strategies are marked •).

Smoke Free Environments for Children

• Since ETS is a Group A human carcinogen, Federally and State funded programs for infants, children, and adolescents should be required to provide a smoke-free environment for populations served by these programs.

• All schools, public and private, should be smoke-free. Drug Free School Zones should include tobacco.

Public environments accessible to children should provide a smoke-free environment.

Health Education

• Tobacco should be targeted by all Federal anti-drug programs involving children and youth.

• The nation's schools should implement tobacco prevention programs within a comprehensive school health program that includes effective curriculum, teacher training, smoke-free facilities, and access to cessation programs for students and school employees.

Congress should provide additional funding for youth-oriented tobacco control programs within existing federal public health programs, including programs for mothers and children, migrants, and Native Americans.

All federally and State funded programs and services for pregnant teenagers should provide an effective program of tobacco use cessation.

Youth Access to Tobacco

• Federal regulations for the implementation of the new provisions related to the enactment and enforcement of minimum age laws prohibiting youth access to tobacco (Synar Amendment) of the June 1992 Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act should be enforceable, effective, and not preempt local and state authorities or jurisdictions from adopting more stringent laws to reduce youth access to tobacco. Implementation of provisions should allow states/jurisdictions to use Substance Abuse and Mental Health block grant funds for enforcement activities.

• Local governments should license and regulate tobacco retailers in the same manner that they now license and regulate retailers of alcoholic beverages.

Federal policy should establish, or provide incentives for states to adopt, age 21 as the minimum age for purchase of tobacco products. Provisions also should be made for strong enforcement of this age limit, with meaningful penalties for violations, through licensing of tobacco retailers.

State and local governments should ban the sale of tobacco products through vending machines, without preempting local jurisdictions from enacting more stringent regulations.

Federal, state, and local governments should effectively ban the distribution of free samples of tobacco products.

Advertising and Promotion

• National groups, including nontraditional partners, should petition the Justice Department and FTC to enforce existing laws regarding tobacco advertising and promotion.

The Federal government should develop a national repository of information on tobacco advertising targeting youth and related counterstrategies.

Federal, State, and local government should ban the distribution of free samples of tobacco products.

Congress should ban tobacco advertising in publications.

Congress should prohibit tobacco logos on promotional items, such as hats and T shirts.

Anti-tobacco coalitions should petition owners of sports and cultural organizations to have smoke-free sports and cultural facilities without tobacco advertising.

State and local organizations should provide tobacco-free sponsorship of sports and cultural events.

No tobacco sponsored events or promotions should occur on government property or in government funded facilities.

Community groups should work toward the elimination of billboards and other public signage advertising tobacco.

The Federal government should fund an aggressive paid counteradvertising campaign to discourage all tobacco use by youth.

Excise Tax

• The Federal excise tax on tobacco should be increased by a minimum of $2 per pack of cigarettes or container of smokeless tobacco.

• An excise tax of at least $2 per pack of cigarettes or container of smokeless tobacco should be imposed on the sale of tobacco products in military commissaries and exchanges stores with proceeds being delivered to support military morale, welfare, and recreation programs.

• States should increase the excise tax on tobacco over current levels by at least $.25 per pack of cigarettes or container of smokeless tobacco. The amount of this tax should increase with inflation. The possibility of tying the tax to a percentage of tobacco product purchase price should be explored. At least a proportion

of resulting revenues should be allocated to tobacco prevention and control in the States.

Campaign Reform

Anti-tobacco coalitions should support efforts to reform congressional campaign financing, including limitations on contributions that can be made by individuals, groups, or PACS to political candidates.

Divestment

Private and public organizations that directly or indirectly serve youth should evaluate their retirement investment holdings and consider divesting stock in companies that manufacture, distribute, and promote tobacco.

Professional Education

Accrediting boards for health professional schools should require instruction in the prevention and control of tobacco use among children and youth.

The National Council for the Accreditation of Teacher Education (NCATE) should require schools of education to provide instruction in comprehensive health education that includes the prevention of tobacco use.

Research

Congress should significantly increase funding for research on the prevention and reduction of cigarette smoking and smokeless tobacco use among children and adolescents and for the diffusion (dissemination, adoption, implementation, and maintenance) of evaluated tobacco prevention programs shown to be effective. Priority areas for research include the development and evaluation of preventive programs for elementary school children, and of both prevention and cessation programs for youth of high school age and young adults. Different models and more targeted programs are needed to reach high risk youth, including especially school absentees and dropouts, those with one or more parents who use tobacco, low-achiever groups, girls and young women, and youth from ethnic minority groups. Research is also needed to strengthen and further test hypotheses about the role of tobacco advertising and promotion in smoking initiation by children and youth. Another research priority is the development and testing of educational approaches that effectively lead parents and other adults to reduce the exposure of children and youth to ETS.

Minority issues

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(With grateful acknowledgement to the work of Robert G. Robinson, DrPH, on which this paper relies heavily)

Introduction

African-Americans:

Tobacco use by African-Americans is responsible for nearly 48,000 deaths each year in the United States. Aggressive targeting of the African-American community by the tobacco industry, particularly in the urban, inner-city environment, exacerbates the difficulty faced by tobacco control advocates in seeking to reduce the burden of tobacco-related disease experienced within the African-American community.

Hispanics:

Tobacco use among Hispanics is less well-documented than tobacco use among African-Americans. It is known that the rates of tobacco use among Hispanic groups are somewhat higher than those observed for non-Hispanic whites. It also is apparent that aggressive targeted marketing by the tobacco industry is not reserved for African-Americans, but also is being aimed at the growing Hispanic population in the United States. For example, tobacco manufacturer Philip Morris is the top advertiser in Hispanic markets.

To help inform efforts to combat the problem of tobacco use by African-Americans and Hispanics, which constitute the two largest "minority" populations in the United States, this background paper summarizes the nature of the problem, the factors contributing to the problem, the issues affecting prevention and intervention strategies, and the tobacco-related public policy issues involving the African-American and Hispanic communities.

Tobacco Use

African-Americans:

As of 1990, 26.2 percent of African-American adults (aged 18 and older) smoked cigarettes, including 32.6 percent of men and 21.2 percent of women, according to the National Health Interview Survey. Prevalence was highest among men who had not completed 12 years of education. In the same year, 25.6 percent of whites in the United States smoked cigarettes, including 27.9 percent of men and 23.5 percent of women. Smoking prevalence in the 20-24 age group, which can be used as an indirect measure of smoking initiation, was 17.3 percent for African-Americans and 28.3 percent for whites. The prevalence among African-Americans aged 20-24 declined by one-third between 1983 and 1987, from 38.7 percent to 25.6 percent, while the smoking rate among whites in this age group declined by 17 percent, from 36.8 percent to 30.5 percent. When considering these figures, it must be kept in mind that the age of initiation for African-Americans is somewhat older than for whites.

It is possible that the decrease in cigarette use among youth is negated by the increase in use of spitting tobacco and snuff. Indeed, between 1970 and 1989, snuff use increased 1500 percent and spitting tobacco use increased 400 percent among males between 17 and 19 years-old. Comparing African-American and white males 17 and older, whites are 2.4 times more likely to use smokeless tobacco. A contrary statistic is the fact that older African-American women in southern states are much more likely to use snuff than are women in the general population. Other predictors of spitting tobacco and snuff are residence in the Southeast, less education, poverty, unemployment and lower income.

Hispanics:

As of 1990, 23.0 percent of Hispanic adults (aged 18 and older) smoked cigarettes, including 30.9 percent of men and 16.3 percent of women, according to the National Health Interview Survey. Prevalence was highest among men who had not completed 12 years of education. Smoking prevalence in the 20-24 age group was 20.7 percent for Hispanics, which was less than the 28.3 percent for whites but more than the 17.3 percent for African-Americans.

Comparisons among Hispanic sub-groups show that smoking rates for women are much lower than those for men, irrespective of sub-group. According to a study published in the *American Journal of Public Health* in December 1990, Mexican-American men have the highest smoking rate among Hispanic sub-groups (42.5 percent), while Puerto Rican women have the highest smoking rate among Hispanic women (30.3 percent). The rates for other Hispanic sub-groups were: Cuban-American men (41.6 percent), Puerto Rican men (39.8 percent), Cuban-American women (24.4 percent) and Mexican-American women (23.8 percent).

Although the prevalence of smoking has been on the decline, rates among younger birth cohorts of Hispanic women have increased over time, while smoking rates for all Hispanic women have remained essentially stable, according to a study published in the *Journal of the American Medical Association* in January 1989. By comparison, according to the same study, whites have

made more progress than Hispanics since the 1960s in reducing their smoking initiation rates.

Smoking rates among Hispanic youth also are of great concern, as 19.4 percent of Hispanics aged 12-17 smoked cigarettes in the preceding year, according to the 1990 National Institute on Drug Abuse National Household Survey on Drug Abuse. This was less than the 25.9 percent of whites in the same age group, but considerably more than the rate of 9.8 percent for African-American adolescents.

Health Consequences of Tobacco Use

African-Americans:

African-Americans suffer from tobacco-related diseases at a higher rate than whites. African-American men and women have a higher incidence of respiratory system, esophagus and oral cavity cancers than do white men and women. They also experience excessive mortality for many tobacco-related cancers. In 1988, nearly 48,000 African-Americans died from preventable, smoking-attributable causes. Smoking-attributable deaths among African-American men (702.9 per 100,000) are more than double those among African-American women (231.5 per 100,000).

African-Americans have not only a higher death rate from cigarette smoking than whites, but have a greater loss of productive years of life. This is because African-Americans tend to become ill from smoking at younger ages than whites. The age-adjusted years of potential life lost (YPLL) attributed to smoking in 1984 was 8.14 for African-Americans and 3.81 for whites. In 1988, the YPLL before age 65 for African-Americans was twice that for whites, and before age 85 the YPLL was 52 percent higher than that for whites.

The percentage of lung cancer mortality attributed to smoking is 86.1 percent. The average lung cancer death rate from 1980 through 1987 for African-Americans was 2.3 times higher than for whites. Estimates are that from 1980 through 1990, lung cancer increased 98.6 percent for African-American females, 86 percent for white females, 31.8 percent for African-American males and 20.7 percent for white males. Lung cancer incidence and mortality are not expected to plateau for African-Americans and whites until after the year 2013. However, because of their higher smoking cessation rate, white male lung cancer mortality is expected to decline in the 1990s, with lung cancer mortality occurring later among African-Americans.

While African-Americans quit more frequently than whites, African-Americans are less likely than whites to remain smoke-free for one year or more. In 1987, the proportion of persons who have ever smoked cigarettes and who have quit smoking was 31 percent for African-Americans and 46.4 percent for whites.

Hispanics:

Several studies have documented a rising lung cancer rate among Hispanic males. For example, as reported in the *American Journal of Public Health* in February 1985, the Colorado Tumor Registry reported a 132-percent increase in lung cancer rates among Hispanic men between 1970 and 1980, compared to a 12-percent increase among white men. One of the study's co-authors, Al Marcus, a cancer specialist at UCLA's Jonsson Comprehensive Cancer Center, said, "There's an epidemic out there. And it hasn't received a lot of attention. There aren't a lot of people studying cancer among Hispanics."

As noted in *Marketing Disease to Hispanics*, published by the Center for Science in the Public Interest (1989), "Dr. John Samet of the University of New Mexico School of Medicine, one of the researchers who documented the increasing lung cancer rates in Hispanic males in New Mexico, said the higher rates are occurring because Hispanic men have started smoking more cigarettes in the last ten to 15 years. In the past, Hispanic smokers smoked far fewer cigarettes per day than their White or Black counterparts. One study, for example, found that Mexican-American males and females smoked about one-half a pack fewer cigarettes per day than Whites ... However, that now seems to be changing."

Intervention to Prevent Tobacco Use

Effectively intervening to prevent African-Americans, Hispanics and other minority population groups from starting or continuing to smoke is key to reducing the burden of tobacco-related death and illness. Pro-health, anti-tobacco efforts can be of either an advocacy or educational nature. Current and proposed interventions include:

- Increases in the tax, and thus price, of tobacco products;
- Bans or restrictions on tobacco advertising and promotion;
- Elimination of access by children and youth to tobacco products; and
- Educational efforts.

Price of Tobacco Products

Adolescents of all races generally have limited disposable income, and their ability to purchase cigarettes is sensitive to increases in the price of cigarettes. Indeed, research, and the experience of other countries, have shown that substantially increasing tobacco prices is the single most effective tool in reducing tobacco use, particularly among children and youth. For example, in Canada, where cigarette taxes were quadrupled between 1984 and 1991 so that they are now about seven times the cumulative (combined federal and state) level in the United States, teenage smoking has been cut by well over half. The US General Accounting Office estimates that if the excise tax on cigarettes were increased by just 21 cents per pack, the number of teenage smokers, white and African-American, in the United States would likely decline by over 500,000, resulting in 125,000 fewer preventable deaths.

Advertising and Promotion, Philanthropy, Influence-Peddling and Related Tactics

Tobacco companies aggressively target cigarette advertising and promotion at the African-American, Hispanic and other minority communities. The influence of advertising and promotion on

tobacco use and prevalence are important criteria in assessing how much control should be exercised on tobacco industry marketing campaigns. The impact of advertising and promotion on the behavior of media is also important. The decision of members of the media, sometimes under the influence of their tobacco advertisers, not to include articles related to tobacco and health directly inhibits the flow of information which might be used by readers to make truly informed choices about tobacco use. In addition, lack of exposure to tobacco-related articles about the health consequences or such issues as tobacco industry marketing campaigns can influence cultural norms that shape perceptions of tobacco use.

Tobacco and alcohol advertising have been the economic mainstays of the African-American press, for example, for decades. For example, in 1950, Philip Morris was attacked by the segregationist publication *White Sentinel* for being "the first cigarette company to advertise in the Negro press." African-American magazines receive proportionately greater revenues from cigarette advertising than do general market magazines. In 1987, tobacco advertisements accounted for 6.1 percent of the advertising in 166 consumer magazines, while the percentage was measurably higher in leading African-American magazines such as *Jet* (10.2 percent), *Essence* (9.2 percent) and *Ebony* (7.5 percent). In 1985, cigarette companies spent $3.3 million on advertisements in *Ebony* alone. Moreover, the tobacco industry heavily markets mentholated cigarettes—including Newport, Kool and Salem—to African-Americans. A comparison of tobacco advertising in magazines preferred by African-Americans and whites, for example, showed that the percentage of menthol cigarettes advertised in *Essence*, *Ebony* and *Jet* was 65.9 percent compared to 15.4 percent in general market publications *Mademoiselle*, *Time*, *Newsweek* and *People*.

Similarly, Philip Morris is now the leading advertiser in Hispanic markets, while RJR Nabisco is in the top 10.

Tobacco companies also support minority-targeted media by underwriting key portions of their annual conferences and conventions, including the dedication in 1987 of the Black Journalism Hall of Fame, the 1991 Mid-Winter Meeting of the Black Press and meetings of the National Newspaper Publishers Association. Tobacco companies also have supported journalism scholarships and internships and provided entry-level opportunities for African-Americans in communications.

Billboards advertising tobacco products are placed in predominantly African-American communities four to five times more often than in white communities. In 1987, for example, tobacco companies spent $5.8 million on advertisements on small billboards, often located close to sidewalks and storefronts, in predominantly African-American neighborhoods, accounting for 37 percent of total advertising in this medium. By comparison, African-Americans comprise approximately 12 percent of the overall population.

Special targeted advertising has been developed by tobacco companies for minority media. Paradoxically, most of this advertising has not been developed by minority-owned agencies. For example, in the past 20 years, only two African-American-owned advertising agencies have been assigned substantial cigarette billings: Burrell Advertising in Chicago, for Marlboro cigarettes in the early 1970s, and Mingo-Jones, for Omni cigarettes in the early 1980s. Burrell has since stated that it would not accept future cigarette accounts.

Data from the six major US cigarette manufacturers reveals that in 1990, United States cigarette advertising and promotional expenditures reached yet another all-time high of $3.9 billion, equivalent to nearly $11 million per day.

There are numerous linkages between social service and civil rights organizations within the African-American community and the tobacco industry. The reasons for this include, among others, the following:

- African-American organizations need money to run their operations, and the tobacco industry is a ready source of such funds, particularly given the decrease in federal and other governmental funds that are available to African-American institutions and organizations. For organizations involved in civil rights lobbying and/or controversial issues, the options for fundraising are even more limited.

- Long-standing personal friendships and business relationships between the traditional leadership of the African-American community and their counterparts in the major cigarette companies might be destabilized by organized African-American opposition to tobacco interests. For example, Vernon Jordan, former president of the National Urban League (NUL), is a member of the board of directors of RJR Nabisco. Margaret Young, the widow of former NUL president Whitney Young, is a member of the board of directors of Philip Morris. Raymond Pritchard, chairman and CEO of Brown & Williamson, serves on the board of directors of the NUL and is an advisor to Opportunities Industrialization Centers of America.

In a similar vein, the tobacco industry successfully targets the African-American and other minority communities by sponsoring entertainment, sporting and cultural events and political and literacy campaigns. For example, according to an internal Philip Morris company document shared by an anonymous source with Yorkshire Television of Great Britain and later with health advocates, in 1991 Philip Morris handed out $17,339,154 in "philanthropic" contributions. Among these contributions were a number of gifts to leading African-American organizations across the United States, a sampling of which follows:

NAACP (national office and various chapters)	$131,500
National Urban League (and chapters)	$329,070
African American Cultural Center	$ 10,000
Associated Black Charities	$ 10,000
Thurgood Marshall Scholarship	$ 50,000
Indiana Black Expo, Inc.	$ 67,500
National Minority AIDS Council	$ 10,000

Black American Political Association	$ 8,000
Alvin Ailey Dance Theater Foundation	$200,920
African American Arts Festival	$ 20,000

Similarly, the Philip Morris document listed, among others, the following contributions made to Hispanic organizations:

National Council of La Raza	$175,000
Hispanic Policy Development	$ 50,000
Ballet Hispanico of New York	$ 3,920
Libertad, Inc.	$300,000
National Hispanic University	$ 30,000

The visibility of African-American elected officials and their power at the local, state and federal levels has led the tobacco lobby to provide strong financial support to these officials and their organizations. Substantial contributions have been made by tobacco interests on an annual basis to the Congressional Black Caucus and the National Black Caucus of State Legislators, as well as individual legislators. For example, according to the internal Philip Morris document cited above, Philip Morris alone gave the Congressional Black Caucus $86,108 in 1991. Similar support has been given to the Congressional Hispanic Caucus.

The tobacco industry's ability to mobilize key segments of African-American, Hispanic and other minority leadership, combined with the contributions to individual politicians and their organizations, makes it difficult for tobacco control advocates to gain support among minority legislative caucuses. However, there are individual elected officials who have been proactive on the issue of tobacco control. Rep. John Lewis (D-GA), one of the leaders in the successful legislative battle to ban smoking on virtually all domestic passenger airline flights, will not accept tobacco and alcohol-related contributions. Rep. John Conyers (D-MI) favors developing alternative funding for organizations such as the Black Congressional Caucus Foundation. According to Conyers, the extent of African-American mortality directly related to the use of tobacco and alcohol requires that leaders and organizations begin to reject tobacco contributions and support.

Access to Tobacco Products

A major contributor to tobacco use among children and adolescents of all ethnic and racial groups is their easy access to tobacco products. While virtually all states have laws prohibiting the sale of cigarettes to individuals younger than 18, not one state adequately enforces its minimum-age law. This failure to take seriously the minimum-age laws contributes directly to the fact that more than 3,000 children start to smoke every day in the United States. Pro-health federal legislators responded by persuading Congress to enact a compromise measure (dubbed the "Synar Amendment") in 1992, which becomes effective in October 1993, requiring all states to:

- Have in force a minimum-age law prohibiting the sale or distribution of any tobacco product to those under age 18; and
- Enforce the minimum-age law "in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18."

The new law prescribes that, if a state fails to satisfy the Department of Health and Human Services in annual reports that it has met this standard, the state will lose 10 percent of specified block grant funds in the first year, increasing to 40 percent in the fourth and all subsequent years.

The Synar Amendment is seen by health advocates as a step in the right direction. At press time, however, regulations implementing the measure have not been finalized, and uncertainty exists as to how the new law will affect states' enforcement efforts.

Educational and Related Interventions

The major tobacco control activities that have dominated the field have been those sponsored by the federal government through the National Institutes of Health and voluntary organizations such as the American Cancer Society (ACS), American Heart Association (AHA) and the American Lung Association (ALA), and have emphasized smoking cessation and mass media educational and school-based programs. These efforts model traditional health promotion goals that seek to alter health status by encouraging individuals to make lifestyle changes. The seven-year demonstration ASSIST initiative, a joint venture by the National Cancer Institute (NCI) and the ACS, includes as a part of its mission the training of personnel in health education, worksite and community organizations in traditional cessation and health education programs. ASSIST's emphasis, however, is on policy and media advocacy targeted at educating broad populations of people, including African-Americans, Hispanics and other minority groups, women, blue-collar workers, rural communities and others.

If new initiatives are to reinforce cessation efforts, it will be important to understand the minimal work done in developing tobacco use cessation programs and materials directed toward African-Americans. Unfortunately, organized professional programs are virtually unavailable to segments of the African-American population, a problem which is exacerbated by the paucity of materials and programs developed for persons at a low socioeconomic level or with minimal literacy. Development of new programs and materials for minority population groups would be beneficial if these programs and materials:

- Are tailored to minority groups' tobacco use patterns;
- Are sensitive to the special obstacles encountered in the minority communities;
- Raise awareness of tobacco's health risks and quitting benefits and bolster primary group norms for cessation; and
- Integrate problem definitions that reflect on the role of the tobacco industry in the community.

New minority-targeted initiatives to reinforce anti-tobacco policy and community-based efforts will need to consider numerous impediments. First, the issue which motivates many urban communities concerns drugs and violence, unemployment, housing,

poverty and under-funded educational and health delivery systems. Drugs are a major concern because of the visible relationship to violence, often random and causing the deaths of innocent children, and the high priority given it by the federal government. Thus, the no more than 10,000 annual deaths attributed to illicit drugs, while not comparable to the 434,000 annual tobacco related deaths, constitute the most immediate and visceral experience felt by the average community resident.

Second, prevention and health promotion receive little support and are not given priority in a health care delivery system oriented to the medical model. Third, the penetration of minority communities by the tobacco industry is pervasive through marketing efforts and financial support of minority organizations and institutions. Fourth, there has been an absence, until recently (viz. the successful coming together and advocacy effort of the Uptown Coalition for Tobacco Control in Philadelphia), of significant African-American, Hispanic and other minority anti-tobacco advocates and community organization support for policy and advocacy initiatives. Fifth, there is no viable infrastructure to enable minority anti-tobacco advocates to communicate, network, plan and establish an agenda based on principles of empowerment and self-determination. Sixth, there has been an absence of culturally sensitive and racially relevant anti-tobacco advocacy and community organizing materials for use in local communities. Finally, viable interactions between minority anti-tobacco advocates and mainstream advocates and organizations have been lacking.

Recommendations

Black, Hispanic, Asian and Native-American communities are under attack by the tobacco companies; they are the targeted communities. As a result, these communities may be designated as a "chronic disaster area" for the purpose of focusing tobacco control activities. Given limited funding, we must also better target resources to communities which suffer excess mortality and morbidity due to tobacco.

To mount effective strategies, this committee decided to focus on children as the front line of tobacco use prevention efforts. Cessation efforts were considered as critical for adults. The committee encourages the other committees to ensure that their recommendations include targeted communities. The committee makes the following recommendations:

I. Data

• *There needs to be improved data on all aspects of tobacco control in African-American, Hispanic, Asian and Native-American communities.* The federal government must take the lead by encouraging the states to collect data uniformly and include race and ethnic data in their data collection activities. The committee welcomes efforts by states to include information regarding tobacco-related deaths on death certificates.

II. Education

• *Counter-advertising is a critical component to education.* Messages must be developed which are culturally competent; this means that the targeted community should be involved in the development of counter-advertisements. Additionally, it is essential to implement both offensive and defensive strategies. For example, the Department of Health and Human Services should be allowed to purchase air time for the ads it develops, materials on counter-heroes within targeted communities should be disseminated, tobacco companies should be made more responsible for their actions, etc.

• *Comprehensive school education is critical for K-12, as well as programs targeted to out-of-school youth.*

III. Leadership and employment

• *We need more leaders.* We need to develop a cadre of leaders of targeted communities to be active at all levels of tobacco control. We need to establish and reinforce communication channels among members of targeted communities. There exists an opportunity to create new political leadership, with children being the driving force and tobacco being the motivator.

• *We need to work with community-based organizations, especially credible ones which have not taken tobacco money.* Long-term funding for programs must be identified from the inception, and included as part of the program strategy.

• *The goals in "Healthy People 2000" should be made more challenging, and the goals for the overall population should be applied equally to all targeted communities.*

IV. Excise tax

• *The committee recommends enactment of a significant and substantial federal excise tax ($2), which is not earmarked.* It is important to note that the primary purpose of this tax is to decrease consumption and not necessarily to raise funds for health-related activities.

• State and local taxes should be increased substantially, and can be earmarked for health.

V. Worksite

• *Given the additional support provided by the recent findings of the Environmental Protection Agency related to the harm caused to nonsmokers by environmental tobacco smoke, all efforts should be made to make worksites smokefree.*

• All federally-funded facilities should be required to be smokefree.